

IN THE DISTRICT COURT OF CLEVELAND COUNTY

STATE OF OKLAHOMA

No. CJ-2017-816

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STATE OF OKLAHOMA, ex rel.,

MIKE HUNTER, ATTORNEY GENERAL

OF OKLAHOMA,

Plaintiff,

v.

(1) PURDUE PHARMA, L.P., et al.,

Defendants.

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COMPLETE CAPTION ON PAGE 2

- - - - - X

VOLUME I

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DEPOSITION OF RUSSELL PORTENOY, M.D.

Thursday, January 24, 2019, 10:49 a.m.

Shaheen & Gordon, P.A.

107 Storrs Street

Concord, New Hampshire 03301

-- Reporter: Kimberly A. Smith, CSR, CRR, CRC, RDR --

Realtime Systems Administrator

U.S. Legal Support

1 IN THE DISTRICT COURT OF CLEVELAND COUNTY

2 STATE OF OKLAHOMA - No. CJ-2017-816

3

4 STATE OF OKLAHOMA, ex rel.,

5 MIKE HUNTER, ATTORNEY GENERAL

6 OF OKLAHOMA,

7 Plaintiff,

8 v.

9 (1) PURDUE PHARMA, L.P.;

10 (2) PURDUE PHARMA, INC.;

11 (3) THE PURDUE FREDERICK COMPANY;

12 (4) TEVA PHARMACEUTICALS USA, INC.;

13 (5) CEPHALON, INC.;

14 (6) JOHNSON & JOHNSON;

15 (7) JANSSEN PHARMACEUTICALS, INC.;

16 (8) ORTHO-McNEIL-JANSSEN PHARMACEUTICALS, INC.,

17 n/k/a JANSSEN PHARMACEUTICALS, INC.;

18 (9) JANSSEN PHARMACEUTICA, INC., n/k/a JANSSEN

19 PHARMACEUTICALS, INC.;

20 (10) ALLERGAN, PLC, f/k/a ACTAVIS PLC, f/k/a

21 ACTAVIS, INC., f/k/a WATSON PHARMACEUTICALS, INC.;

22 (11) WATSON LABORATORIES, INC.;

23 (12) ACTAVIS LLC; and

24 (13) ACTAVIS PHARMA, INC., f/k/a WATSON PHARMA, INC.,

25 Defendants.

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24

25

1 I N D E X

2

3 WITNESS: Russell Portenoy, M.D.

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24 Original exhibits retained by reporter to be

25 returned to Nix Patterson LLP

1 THE VIDEO OPERATOR: Good morning.

2 We're on the record. The time on the monitor is

3 10:49. Today is the 24th day of January, 2019.

4 We're here at 107 Storrs Street, Concord, New

5 Hampshire, for the purpose of taking the videotape

6 deposition of Dr. Russell Portenoy in the matter of

7 the State of Oklahoma vs. Purdue Pharma, et al.

8 The videographer is James Soto, the

9 court reporter is Kim Smith, both with U.S. Legal

10 Support. All counsel will be noted in the

11 stenographic record.

12 Please administer the oath.

13 RUSSELL PORTENOV, M.D.,

14 having been first duly sworn by the court

15 reporter, was deposed and testified as follows:

16 EXAMINATION

17 BY MR. BECKWORTH:

18 Q. Can you tell the judge and jury your name,
19 please, sir.

20 A. I'm Dr. Russell Portenoy.

21 Q. Is it Portenoy?

22 A. Yes.

23 Q. I'll do my best with that. Dr. Portenoy,

24 I am Brad Beckworth. I represent the State of

25 Oklahoma through its Attorney General, Mike Hunter.

1 Do you understand that?

2 A. Yes.

3 Q. Now, you are here today to give testimony
4 under oath under penalty of perjury about some
5 things that have happened in your life and career
6 over the last 20 years, correct?

7 A. Yes.

8 Q. Let's start with this. You're currently
9 the executive director of the MJHS Institute For
10 Innovation and Palliative Care and the chief medical
11 officer of MJHS as well, correct?

12 A. Chief medical officer of MJHS Hospice and
13 Palliative Care.

14 Q. What is MJHS?

15 A. It's the d/b/a of Metropolitan Jewish
16 Health System.

17 Q. And where is that located?

18 A. New York City.

19 Q. You've been in this position or working for
20 MJ since about 2014, correct?

21 A. That's correct.

22 Q. Prior to that time, you were employed by
23 something called the Beth Israel Medical Center in
24 New York, correct?

25 A. Correct.

1 Q. While it changed some parts of its name
2 over time, Beth Israel will reflect that entity,
3 correct?

4 A. Yes.

5 Q. You worked there from about 1997 to 2014,
6 correct?

7 A. Yes.

8 Q. And at some point, you were the chair of
9 Beth Israel's Department of Pain Medicine and
10 Palliative Care?

11 A. For that entire period.

12 Q. You understand that today, I'm here on
13 behalf of the State of Oklahoma due to a trial we
14 have against certain pharmaceutical companies?

15 MR. ERCOLE: Objection to form, leading.

16 BY MR. BECKWORTH:

17 Q. You understand that, correct?

18 A. I understand that, yes.

19 Q. You also understand that one of the
20 defendants in this case is Purdue?

21 A. Yes.

22 Q. And related entities to Purdue?

23 A. Yes.

24 Q. You also understand that Janssen and
25 Johnson & Johnson are defendants as well?

1 A. Yes.

2 Q. You understand that Teva is a defendant?

3 A. Yes.

4 Q. And Cephalon?

5 A. Yes.

6 Q. And you see in your room -- the room we're
7 in today that the drug companies that I've just
8 listed, they're represented by lawyers, correct?

9 A. Yes.

10 MR. ERCOLE: Objection to form.

11 BY MR. BECKWORTH:

12 Q. And as we sit here today, there's only one
13 lawyer from the State of Oklahoma representing any
14 defendant in this case, and this is this lady at the
15 end of the room here with Johnson & Johnson.

16 Do you see her?

17 MR. ERCOLE: Objection to the form.

18 THE WITNESS: I see the lady at the end
19 of the table, yes.

20 BY MR. BECKWORTH:

21 Q. There's no other lawyer licensed in the
22 State of Oklahoma representing any other defendant
23 in this case?

24 MR. ERCOLE: Objection to form.

25 THE WITNESS: I wouldn't know where

1 licenses derive from.

2 BY MR. BECKWORTH:

3 Q. Well, you'll be asked questions by some of
4 the drug company lawyers here, and I think you'll
5 see that none of them are licensed in the State of
6 Oklahoma.

7 MR. ERCOLE: Objection to form.

8 BY MR. BECKWORTH:

9 Q. I am licensed in the State of Oklahoma,
10 sir, and I have an office in the State of Oklahoma,
11 and it's my great privilege to represent the State
12 of Oklahoma in this case.

13 Now, over the course --

14 MR. ERCOLE: Objection to form. Move to
15 strike. No question was asked.

16 BY MR. BECKWORTH:

17 Q. Over the course of your career, you have
18 been paid to be a speaker or advisor to many
19 pharmaceutical companies who make opioid products,
20 correct?

21 A. Correct.

22 Q. And you've been paid to be a speaker or
23 advisor for the Purdue defendants?

24 A. Yes.

25 Q. Also for the Janssen entity?

1 A. Yes.

2 Q. And Johnson & Johnson?

3 A. Yes.

4 Q. Teva?

5 MR. ERCOLE: Objection to form.

6 THE WITNESS: I'm not actually sure
7 about Teva. Teva acquired another company.

8 BY MR. BECKWORTH:

9 Q. Cephalon?

10 A. Cephalon. Cephalon, yes.

11 Q. You've done speaking or advising work for
12 Cephalon?

13 A. Yes.

14 Q. You may have done it for Teva as well?
15 You're just not sure as you sit here?

16 A. I'm not sure, right.

17 Q. You also were involved in a group called
18 the American Pain Society?

19 A. Yes.

20 Q. You were on the board?

21 A. Yes.

22 Q. And for a few years, you served as its
23 president?

24 A. Just a single term, single one-year term.

25 Q. Of the American Pain Society?

1 A. Yes.

2 Q. You understand that the defendants from the
3 drug world that are here today provided funding to
4 the American Pain Society?

5 MR. ERCOLE: Objection to form.

6 THE WITNESS: Yes.

7 BY MR. BECKWORTH:

8 Q. And they did that while you were on the
9 board?

10 MR. ERCOLE: Objection to form.

11 THE WITNESS: I'm not sure who provided
12 funding during that period of time. I would assume
13 that they did.

14 BY MR. BECKWORTH:

15 Q. And you understand though that many
16 pharmaceutical companies provided funding to the
17 American Pain Society?

18 MR. ERCOLE: Objection to form.

19 THE WITNESS: Yes.

20 MR. BECKWORTH: Just to be clear, I need
21 to be able to ask my question and get an answer.
22 I understand that you don't want his answers to be
23 heard. Let him answer or let me finish my question,
24 please. If not, I will have to get the judge on the
25 phone and we'll have a hearing.

1 Some of us will actually be at the trial
2 of this case. I know that you won't. We need to
3 let the jury hear it. I'm not going to argue that
4 you've waived an objection if he starts talking and
5 you didn't get it out first, okay? We'll have that
6 agreement?

7 MR. ERCOLE: Are you finished with your
8 commentary?

9 MR. BECKWORTH: Yes.

10 MR. ERCOLE: I'm going to now respond to
11 the argumentative commentary you just made.

12 MR. BECKWORTH: There's nothing funny
13 about the death of opioids, sir.

14 MR. ERCOLE: I completely agree.
15 There's nothing funny either about you taking the
16 deposition of a witness and asking leading questions
17 from the start when this is your witness, as Judge
18 Hetherington's order clearly makes perfectly clear.

19 MS. SPENCER: I'll object to that. He's
20 my witness -- he's my witness.

21 MR. ERCOLE: Let me just finish.

22 So if you are going to continue in that
23 style, unfortunately, I'm going to be forced to
24 continue to make that objection, which is fine.

25 MR. BECKWORTH: Are you --

1 MR. ERCOLE: Let me just finish, just
2 like I will let you finish. So I will continue to
3 do that and we can move forward.

4 BY MR. BECKWORTH:

5 Q. Sir, you're not the State of Oklahoma's
6 witness, are you?

7 A. No.

8 Q. You don't work for us?

9 A. No, I do not.

10 Q. I have no control over you?

11 A. You do not.

12 Q. You have no purpose in helping me win our
13 lawsuit?

14 A. No.

15 Q. You're here as an independent third party,
16 correct?

17 A. Yes.

18 Q. You're represented by your own counsel,
19 correct?

20 A. I am.

21 Q. There's nothing to prevent you from saying
22 things that may be adverse to our case, correct?

23 A. That's true.

24 Q. You're here to speak the truth?

25 A. That's true.

1 Q. I have no control over you?

2 A. That's true.

3 Q. Now, you also were involved with a group
4 called the American Pain Foundation?

5 A. Yes.

6 Q. You served on its board?

7 A. Yes.

8 Q. You understand that the drug company
9 defendants that are here in this case provided
10 funding to the American Pain Foundation?

11 A. Yes.

12 Q. Now, at some point in your career, you've
13 prepared a résumé, correct?

14 A. Yes.

15 MR. BECKWORTH: I'm going to hand to you
16 what we'll mark as Portenoy Exhibit 1.

17 May I have a sticker. Thank you very
18 much.

19 (Portenoy Exhibit 1 was marked
20 for identification.)

21 BY MR. BECKWORTH:

22 Q. Sir, this is a document that your attorney,
23 Mrs. Spencer, just provided to me. It's an updated
24 copy of your résumé. I'm going to hand this to you
25 as Plaintiff's Exhibit 1 to the Portenoy deposition.

1 Is Exhibit 1 the résumé that your
2 attorney handed us today?

3 A. Yes.

4 Q. Does this résumé set out the summary of
5 your work, education, and experience?

6 A. Yes, it does.

7 Q. Is it a record that you created?

8 A. Yes.

9 Q. Is it a record that you kept?

10 A. Yes.

11 Q. And is it a fair statement of the events,
12 conditions, and information set forth in that
13 document?

14 A. I'm not exactly sure how to interpret those
15 words.

16 Q. The document that's in front of us is a
17 fair summary of your experience, work, and
18 qualifications as a professional?

19 A. Yes.

20 Q. Now, you are a medical doctor?

21 A. Yes.

22 Q. You've treated pain patients prior to
23 today?

24 A. Yes.

25 Q. You still are doing that?

1 A. Yes.

2 Q. You have a background in neurology?

3 A. Yes.

4 Q. But you are not a trained psychiatrist?

5 A. That's correct.

6 Q. You're not a board certified addiction
7 specialist?

8 A. That's correct.

9 Q. You do not have experience diagnosing
10 patients with opioid addiction using established DSM
11 criteria as an addiction specialist, correct?

12 A. That's true.

13 MR. ERCOLE: Objection to form.

14 BY MR. BECKWORTH:

15 Q. Your answer was, I'm correct?

16 A. That's true. Yes, you are correct.

17 Q. And you do not have experience treating
18 opioid addiction from a psychiatric point of view?

19 A. That's true.

20 Q. Now, you have signed a declaration in this
21 case, correct?

22 A. Yes.

23 Q. And just to go over this again. You and I
24 had never met before today, correct?

25 A. That's correct.

1 Q. I met you less than an hour ago here at
2 your attorney's office?

3 A. That's correct.

4 Q. We shook hands; we introduced ourselves?

5 A. Yes.

6 Q. And you left the room?

7 A. I did.

8 Q. Did you and I have any conversation outside
9 the presence of your attorney?

10 A. No.

11 Q. Have you ever met with anyone, to your
12 knowledge, representing the State of Oklahoma about
13 this lawsuit prior to this very day?

14 A. No.

15 Q. To your knowledge, have I ever been to the
16 State of New Hampshire to meet with your attorney
17 about this case?

18 A. No.

19 Q. On Friday, January 18, you, sir, signed a
20 declaration in this case, correct?

21 A. I'd have to check the date. I signed a
22 declaration, but I want to be accurate about the
23 date.

24 MR. BECKWORTH: I'm going to hand you
25 now what we'll mark as Plaintiff's Exhibit 2 to the

1 Portenoy deposition.

2 (Portenoy Exhibit 2 was marked
3 for identification.)

4 MR. BECKWORTH: Hand that to you. If
5 you'll use the copy with the sticker and hand the
6 other one to your attorney, please.

7 THE WITNESS: Thank you.

8 MS. SPENCER: Thank you.

9 BY MR. BECKWORTH:

10 Q. Now --

11 MS. SPENCER: Before we get into the
12 declaration, I'd like to put a statement on the
13 record.

14 MR. BECKWORTH: Sure.

15 MS. SPENCER: This is Amy Spencer. I am
16 the attorney for Dr. Russell Portenoy. In reviewing
17 the declaration in preparation for this deposition,
18 I noticed that there is a typo in paragraph 3 of the
19 declaration. It does not change the substance.

20 However, in the last sentence, it
21 currently reads, "The proffer agreement with those
22 plaintiffs can be voided and the original lawsuits
23 may be reinstated against me if my statements are
24 recklessly and materially not truthful or accurate."

25 Rather than the proffer agreement, it is

1 actually the settlement agreement that provides
2 those same terms. So on the record, I would request
3 that we replace the word "proffer" with
4 "settlement."

5 MR. BECKWORTH: No objection from --

6 MS. SPENCER: And that is my -- that is
7 my fault.

8 MR. BECKWORTH: There's no objection
9 from the State of Oklahoma.

10 MR. COLEMAN: No objection from the
11 defendants.

12 MS. SPENCER: Thank you all.

13 MR. BECKWORTH: We may also have one
14 other typo. Let's just get that out of the way.
15 I believe that's in paragraph 30. At the very first
16 of paragraph 30, it says, "Of the defendants and
17 drugs in this case," and it lists several entities.
18 Just for the record, Endo, Insys, Mallinckrodt are
19 not defendants in this case.

20 MS. SPENCER: No objection.

21 MR. BECKWORTH: Other than that, that's
22 all the changes that I'm aware of.

23 MR. ERCOLE: I mean, are we asking the
24 witness questions? If you have a question about
25 whether the declaration is truthful, ask the witness

1 the question.

2 MR. BECKWORTH: Are you done? Are you
3 done?

4 MR. ERCOLE: My point's a clear one.
5 So if you have a question, just ask the witness a
6 question.

7 MS. SPENCER: I was putting something on
8 the record that --

9 MR. ERCOLE: Understood. And that was
10 the point that you made. And this is a separate
11 issue as to whether the State is unilaterally going
12 to change the declaration. So I would --

13 MS. SPENCER: Okay.

14 BY MR. BECKWORTH:

15 Q. Now, Dr. Portenoy, Exhibit 2 that we just
16 gave you is a declaration that you signed in this
17 case, correct?

18 A. Yes.

19 Q. And if you'll turn to the last page,
20 page 35, the date of this is actually January 17,
21 2019, correct?

22 A. Correct.

23 Q. Now, your attorney just made for the record
24 some changes in paragraph 3, correct?

25 A. Correct.

1 Q. Do you agree with those changes?

2 A. Yes.

3 Q. I also put on the record that there are
4 certain entities listed as defendants in this case
5 that actually are not, and those are in paragraph 30,
6 correct?

7 A. Correct.

8 MR. ERCOLE: Objection to form.

9 BY MR. BECKWORTH:

10 Q. And you understand the changes that we just
11 discussed?

12 A. I do.

13 Q. Now, this declaration is based on your
14 personal knowledge, correct?

15 A. Yes.

16 Q. It is based on your professional
17 experience?

18 A. Yes.

19 Q. It's based upon direct interactions that
20 you had with the pharmaceutical industry?

21 A. Yes.

22 MR. ERCOLE: Objection to form.

23 BY MR. BECKWORTH:

24 Q. And those direct interactions include
25 interactions with Purdue and its related companies?

1 MR. ERCOLE: Objection to form.

2 THE WITNESS: Yes.

3 BY MR. BECKWORTH:

4 Q. They include interactions with Janssen?

5 MR. ERCOLE: Objection to form.

6 THE WITNESS: Yes.

7 BY MR. BECKWORTH:

8 Q. Those experiences include interactions with

9 Johnson & Johnson?

10 MR. ERCOLE: Objection to form.

11 THE WITNESS: Yes.

12 BY MR. BECKWORTH:

13 Q. Those experiences include interactions with

14 Teva?

15 MR. ERCOLE: Objection to form.

16 THE WITNESS: Again, my only concern

17 about the Teva is that I'm not sure that I worked

18 with Teva representatives or the company that Teva

19 purchased. So I'll say that I'm not sure about the

20 Teva interactions.

21 BY MR. BECKWORTH:

22 Q. You understand that you've had interactions

23 with Cephalon?

24 A. Yes.

25 MR. ERCOLE: Objection to form.

1 BY MR. BECKWORTH:

2 Q. And Cephalon's an entity that Teva
3 purchased?

4 A. Yes.

5 Q. In fact, it purchased it after Cephalon
6 pled guilty to a federal crime?

7 MR. ERCOLE: Objection to form.

8 THE WITNESS: My understanding, yes.

9 BY MR. BECKWORTH:

10 Q. And you're represented by Mrs. Amy Spencer,
11 who's to your left, right?

12 A. Yes.

13 Q. You're not represented by any of these drug
14 company lawyers, are you?

15 A. No.

16 Q. You notice that every time I ask a
17 question, they object?

18 A. I do, yes.

19 Q. Now, let's turn to paragraph 3 of your
20 declaration. Paragraph 3 of your declaration, you
21 state that you've agreed to cooperate with certain
22 plaintiffs who have entered into settlement
23 agreements with you, dismissing you as a defendant
24 in their cases.

25 Do you see that?

1 A. Yes.

2 Q. It also says that those plaintiffs agree to
3 dismiss you in exchange for your truthful
4 cooperation, correct?

5 A. Yes.

6 Q. And that there is a proffer agreement,
7 which your attorney just clarified as a settlement
8 agreement, that can be voided and those lawsuits can
9 be reinstated against you if your statements are
10 recklessly and materially not truthful or accurate,
11 correct?

12 A. Correct.

13 Q. That refers to other litigation, not the
14 case that you're in for today's purposes.

15 Do you understand that?

16 A. Yes.

17 Q. Do you understand that, as we talked about
18 a moment ago, you and I have never met before,
19 correct?

20 A. Correct.

21 Q. There is no proffer agreement with the
22 State of Oklahoma, correct?

23 A. Correct.

24 Q. There is no formal settlement agreement
25 with the State of Oklahoma, correct?

1 A. Correct.

2 Q. Now, you did do a declaration that's very
3 similar, almost identical to this one, in other
4 cases, correct?

5 A. Yes.

6 Q. You have not been deposed or put under oath
7 for trial testimony in those cases, correct?

8 A. That's correct.

9 Q. In fact, there was an attempt to do that
10 today, and it's not going forward, correct?

11 A. Correct.

12 Q. Now, at some point in those cases, you met
13 with some of the lawyers representing other
14 governments and other persons suing different
15 pharmaceutical-related companies, correct?

16 MR. ERCOLE: Objection.

17 MS. SPENCER: Objection, compound. If
18 you could break down governments and lawyers
19 representing other companies, that would be helpful.

20 BY MR. BECKWORTH:

21 Q. You understand that in these other cases,
22 there are lawyers that represent states that are
23 suing the pharmaceutical industry?

24 MR. ERCOLE: Objection to form.

25 THE WITNESS: I don't actually know

1 whether those firms are representing states or
2 municipalities within those states.

3 BY MR. BECKWORTH:

4 Q. You understand they're representing some
5 type of government entity?

6 A. Yes, I do.

7 Q. And at some point, you met in person with
8 attorneys representing other entities, correct?

9 A. Yes, I did.

10 Q. They've met with you?

11 A. Yes.

12 Q. In the presence of your attorney?

13 A. Yes.

14 Q. And at some point, a draft declaration was
15 provided to you?

16 A. Yes.

17 Q. And your attorney?

18 A. Yes.

19 Q. Did you just sign the declaration as is
20 that was provided to you?

21 A. No.

22 Q. What did you do?

23 A. I made extensive revisions in the
24 declaration, deleted paragraphs, added paragraphs,
25 and edited other paragraphs.

1 Q. And when that declaration was provided to
2 you, was it provided to you out of nowhere, or was
3 it the result of meetings and interactions that you
4 and your attorney had had with the attorneys on the
5 other side?

6 A. The declaration -- the first draft of the
7 declaration was provided to my attorney by
8 plaintiffs, and I received it from my attorney.

9 Q. But you had already met with them before
10 you got the first draft?

11 A. I met with plaintiff's attorneys prior --
12 at the proffer session -- only at the time of the
13 proffer session after the proffer agreement was
14 signed.

15 Q. And the declaration draft that was sent to
16 you is based upon that session and the information
17 that had been exchanged, as I understand; is that
18 correct?

19 MR. ERCOLE: Objection to form.

20 MS. SPENCER: He can answer if he knows.

21 THE WITNESS: I think there's a timing
22 issue here because the declaration actually was
23 produced many months after the proffer session.

24 BY MR. BECKWORTH:

25 Q. And that's my question. It came many

1 months after the proffer session?

2 A. That's correct.

3 Q. What I'm trying to get at, it was the
4 product of interviews and sessions and information
5 that had been gathered?

6 MR. EHSAN: Object to form.

7 MS. SPENCER: He can only answer if he
8 knows.

9 BY MR. BECKWORTH:

10 Q. If you know.

11 A. Yes. I don't know.

12 Q. When you got the declaration, you made
13 extensive changes to it?

14 A. I did, yes.

15 Q. The declaration that you ultimately signed,
16 sir, those are your words, correct?

17 A. Correct.

18 Q. They're words you either drafted or
19 adopted?

20 A. That's correct.

21 Q. You would not sign something that was
22 false?

23 A. That's true.

24 Q. When you signed the declaration in the
25 other cases, you did so under penalty of perjury?

1 A. Correct.

2 Q. And is there anyone here holding you
3 against your will that forced you to sign that under
4 duress?

5 A. No.

6 Q. When you made agreements in those cases to
7 have lawsuits dropped against you, there was a
8 condition to that, correct?

9 A. Correct.

10 Q. If you testify dishonestly, then they don't
11 have to drop those agreements [sic]?

12 MS. SPENCER: Objection. It's
13 recklessly and materially not truthful or accurate,
14 for the record.

15 BY MR. BECKWORTH:

16 Q. If you testify recklessly and materially
17 not truthful or accurately, then any agreements with
18 those entities are off?

19 A. That's correct.

20 Q. Meaning that the release of you in those
21 cases is based upon you doing what you swore to do
22 just moments ago, which is to tell the truth,
23 correct?

24 A. That's correct.

25 MR. ERCOLE: Objection to form.

1 BY MR. BECKWORTH:

2 Q. Now, in our case, the State of Oklahoma's
3 case, we got a copy of the declaration that was
4 being drafted in that case, and you've agreed to
5 sign a version in our case, correct?

6 A. Correct.

7 Q. The differences in the declaration are the
8 names of the parties that are on the front page,
9 correct?

10 A. Correct.

11 Q. And as we just went through, like
12 paragraph 30, some of the defendants in this case
13 are different than those in other cases?

14 A. That's correct.

15 Q. Now, in our case, there is no proffer
16 agreement?

17 A. Correct.

18 Q. There's no formal settlement agreement?

19 A. Correct.

20 Q. As we established, we've never met before
21 to negotiate this?

22 A. True.

23 Q. And you have signed the declaration that is
24 now Exhibit 2 under penalty of perjury, correct?

25 A. Correct.

1 Q. Meaning you swore that the statements in
2 there were true, correct?

3 A. Correct.

4 Q. And that they were yours?

5 A. That's correct.

6 Q. And as we established earlier, the
7 statements contained in Exhibit 2 are based upon
8 your personal knowledge, experience, skill and
9 training?

10 A. Yes.

11 MR. ERCOLE: Objection to form.

12 MR. EHSAN: Object to form.

13 BY MR. BECKWORTH:

14 Q. And we're here today, your attorney,
15 Mrs. Spencer, is here in the room?

16 A. Yes.

17 Q. You've gotten the declaration in front of
18 you?

19 A. Yes.

20 Q. Are these statements that you made in that
21 declaration true to the best of your knowledge?

22 A. Yes.

23 Q. Do you adopt the statements in Exhibit 2 in
24 their entirety?

25 A. I do.

1 Q. Are they true?

2 A. Yes.

3 Q. Do you swear that they're true?

4 A. Yes.

5 Q. Now, you understand that we have not sued
6 you in our case, correct?

7 A. Correct.

8 Q. You also understand that I've represented
9 to your attorney that the State of Oklahoma has no
10 intent to add you as a defendant in our case,
11 correct?

12 A. Correct.

13 Q. But we've signed no formal settlement
14 agreement?

15 A. That's correct.

16 Q. You're here under the trust that you're
17 going to tell the truth and that what I told your
18 attorney is true?

19 A. That's correct.

20 Q. That's the only agreement that you know of
21 in this case?

22 A. That's true.

23 Q. Now, you know that the drug companies
24 didn't want this deposition to go forward, correct?

25 MR. ERCOLE: Objection to form.

1 MS. SPENCER: He can only answer if he
2 knows.

3 THE WITNESS: I don't know the details
4 in that regard, no.

5 BY MR. BECKWORTH:

6 Q. You know there have been some efforts to
7 have this deposition not occur?

8 A. Yes.

9 MR. ERCOLE: Objection to form,
10 mischaracterizes.

11 BY MR. BECKWORTH:

12 Q. And you hear the drug companies pretty much
13 every time I ask you a question, they object, right?

14 A. Yes.

15 Q. Now, I'd like to go through your
16 declaration in some detail today. But let's just
17 start with this.

18 You know that there are people that have
19 accused you of playing some role in creating or
20 causing what's commonly referred to as an opioid
21 crisis in this country? You're aware of that?

22 A. Yes.

23 Q. You're aware that you've been sued by some
24 entities claiming that you had responsibility for
25 that?

1 A. Yes.

2 Q. You understand though that we haven't sued
3 you for that?

4 A. Yes.

5 Q. Now, I'm going to make [sic] a few questions
6 here and we'll see how this goes throughout the day.
7 But I'm going to tell you what -- I'm going to ask
8 you some questions about what I think happened, and
9 you can tell me if I'm wrong.

10 You're a doctor?

11 A. Yes.

12 Q. You spent your career dealing with the pain
13 industry?

14 A. Um --

15 Q. Or the treatment of chronic pain?

16 A. Yes.

17 Q. Palliative care?

18 A. Yes.

19 Q. Cancer care?

20 A. Yes.

21 Q. You've done quite a bit of work and
22 research and publication about those things?

23 A. Yes, I have.

24 Q. You understand that you had influence?

25 A. Yes.

1 Q. I'm not trying to play to your ego, but you
2 were viewed as an important or influential
3 spokesperson on many issues related to the treatment
4 of pain in America; would you agree with that?

5 A. I would take -- have some concerns about
6 the word "spokesperson." I never spoke for anybody
7 except myself.

8 Q. A speaker?

9 A. A speaker, yes.

10 Q. But you were paid to speak?

11 MR. ERCOLE: Objection to form.

12 THE WITNESS: In some contexts, yes.

13 At other times, no.

14 BY MR. BECKWORTH:

15 Q. And you understand through your dealings
16 with the pharmaceutical industry that they advertise?

17 A. Yes.

18 Q. That they market?

19 A. Yes.

20 Q. And there's a difference between
21 advertising on TV and marketing to health care
22 professionals?

23 A. Yes.

24 Q. You understand that some of the ways that
25 the drug company defendants marketed was to have

1 dinners and presentations where doctors spoke to
2 other doctors?

3 A. Yes.

4 MR. ERCOLE: Objection to form.

5 BY MR. BECKWORTH:

6 Q. You understand that they used marketing
7 materials?

8 A. Yes.

9 Q. That they partnered with different third-
10 party advocacy groups or academic groups to hold
11 seminars and symposiums and conferences?

12 MR. ERCOLE: Objection to form.

13 THE WITNESS: Yes.

14 BY MR. BECKWORTH:

15 Q. And that doctors would attend those types
16 of things, correct?

17 A. Correct.

18 MR. ERCOLE: Same objection.

19 BY MR. BECKWORTH:

20 Q. As well as other health care providers?

21 A. Yes.

22 Q. And you understand that doctors could be
23 influenced by the information they obtained from any
24 of the types of things that we just spoke about?

25 MR. ERCOLE: Same objection.

1 THE WITNESS: Yes.

2 BY MR. BECKWORTH:

3 Q. And you understand that pharmaceutical
4 companies, at least the ones here in this room, they
5 weren't providing this type of education pro bono,
6 meaning they just did it for completely altruistic
7 purposes?

8 MR. ERCOLE: Objection to form.

9 BY MR. BECKWORTH:

10 Q. You know that?

11 A. So I interacted with the industry for many
12 years on a large number of educational conferences,
13 as well as individual opportunities to lecture.
14 It has always been clear to me that the dollars that
15 were placed into the effort to expand education had
16 an ultimate purpose to assist their drug in the
17 commercial market.

18 But I also think that at least with
19 respect to chronic pain, there was an effort on the
20 part of some in the industry to make sure that the
21 medical community got educated because the problem
22 of public -- of chronic pain was viewed as such a
23 public health problem.

24 Q. The view that pain needed to be treated?

25 A. Yes.

1 Q. And, of course, one of the ways that you
2 treat chronic pain if it's identified as a public
3 health problem is through the drugs that each of the
4 defendants in this room make and sell, right?

5 A. One of the ways to do it, yes.

6 Q. Including opioids?

7 A. That's correct.

8 Q. And you understand, because you're a
9 doctor, that when you have all of this information
10 coming at you, it forms part of the basis of a
11 doctor's knowledge?

12 MR. ERCOLE: Objection to form.

13 THE WITNESS: Yes, that's true.

14 BY MR. BECKWORTH:

15 Q. And it has the potential to influence
16 decision making?

17 A. Yes.

18 Q. And that's part of its intent?

19 A. That's correct.

20 MR. ERCOLE: Objection to form.

21 BY MR. BECKWORTH:

22 Q. Now, what I want to talk with you about
23 today is whether you believe that the drug companies
24 in this room used the work that you did and the work
25 that others did to try to improperly influence the

1 decision making of health care providers in this
2 country, okay?

3 MR. ERCOLE: Objection to form.

4 THE WITNESS: Okay.

5 BY MR. BECKWORTH:

6 Q. And you believe, in fact, that that did
7 happen?

8 A. Yes.

9 Q. You're just one person?

10 A. That's true.

11 Q. You don't have the ability by yourself to
12 create an opioid crisis, do you?

13 A. I don't. No, I don't.

14 Q. If there is one, it took a lot of factors?

15 A. That's correct.

16 Q. Including each of the drug company
17 defendants sitting in this room?

18 MR. ERCOLE: Objection to form.

19 THE WITNESS: Including some of the
20 actions taken by each of the drug companies, yes.

21 BY MR. BECKWORTH:

22 Q. Their actions?

23 A. Their actions.

24 Q. Including the way they used your work?

25 MR. ERCOLE: Objection to form.

1 THE WITNESS: I believe that's true,
2 yes.

3 BY MR. BECKWORTH:

4 Q. Make sure I heard that right over the
5 objection. You said what?

6 A. I believe that that's true, yes.

7 Q. Thank you. Now, throughout your career,
8 you accepted financial support -- Well, let's go
9 back to the last question.

10 You said you believe what I said is
11 true, right?

12 A. Yes.

13 Q. Again, the drug companies that are sitting
14 here in the room that we're referring to include
15 Purdue, correct?

16 A. Yes.

17 Q. Janssen?

18 A. Yes.

19 Q. Johnson & Johnson?

20 A. Yes.

21 Q. Teva?

22 A. Yes.

23 Q. Cephalon?

24 A. Yes.

25 Q. All those are included in the statement you

1 just made?

2 A. Yes.

3 MR. ERCOLE: Objection to form.

4 BY MR. BECKWORTH:

5 Q. Your answer was yes, all those defendants
6 are included in the statement you made?

7 A. Yes.

8 Q. Thank you.

9 A. That's true.

10 Q. Now, throughout your career, it is true
11 that one way or another, you accepted financial
12 support from drug companies?

13 A. Yes.

14 Q. Those payments included some payments that
15 were made to you directly?

16 A. Yes.

17 Q. Those payments also included payments made
18 to your institutional employer to support research
19 or academic activities?

20 A. That's correct.

21 Q. And one way that you were paid, sir, is
22 through something called an honoraria for speaking
23 engagements?

24 A. Yes.

25 Q. I'm not sure everyone that's going to be

1 listening to you understands what honoraria is. Can
2 you describe that.

3 A. An honorarium is a fee paid by the sponsor
4 of a conference so that the speaker will come to the
5 conference and give a lecture.

6 Q. And oftentimes the drug companies could not
7 pay an honoraria directly for an education
8 conference, right?

9 MR. ERCOLE: Objection to form.

10 THE WITNESS: I'm not sure how to
11 interpret the question. Sorry.

12 BY MR. BECKWORTH:

13 Q. Well, if you were giving a speech or anyone
14 were giving a speech at certain types of educational
15 conferences, say for a hospital, the drug company
16 could not pay you directly for that work?

17 MR. ERCOLE: Objection to form.

18 THE WITNESS: So probably the best
19 example of what you're saying is that if the drug
20 company was sponsoring a conference at a
21 professional society meeting such as an annual
22 meeting of the professional society, the
23 educational -- the educational payment would go to
24 the professional society, and then the professional
25 society may be able to transfer an honorarium to the

1 speakers.

2 BY MR. BECKWORTH:

3 Q. Right. So that's exactly what I was
4 saying. So, for example, if you gave a speech at a
5 hospital in Oklahoma for an education event, the way
6 that could work was that the drug company would pay
7 money to the institution, and then your fee would be
8 paid by the institution, not directly from the drug
9 company?

10 A. Yeah. In the early part of the time that
11 we're talking about, it was much more common for an
12 honorarium to be offered to the physician personally.

13 Then as the rules pertaining to
14 continuing medical education became more stringent,
15 the pharmaceutical industry began to a much greater
16 extent providing funding to the organizational
17 sponsor of the conference, and then that sponsor
18 would pay the honorarium. So there was a shift over
19 time to the perspective that you were describing.

20 Q. So unless somebody in attendance at one of
21 these talks had actually seen the paperwork, they
22 wouldn't know where the speaker's payment was
23 actually coming from?

24 MR. ERCOLE: Objection to form.

25 THE WITNESS: In these continuing

1 medical education conferences, especially as the
2 rules became more stringent, there was always
3 disclosure. So both the speakers individually and
4 the conference planners needed to disclose to the
5 audience the source of funding.

6 BY MR. BECKWORTH:

7 Q. But that's something that happened not that
8 long ago?

9 MR. ERCOLE: Objection to form.

10 THE WITNESS: That increased stringency,
11 I have trouble dating it honestly. It has been a
12 while, but I can tell you that if we're talking
13 about an epoch that started in the late '80s, it was
14 much less stringent at that time.

15 BY MR. BECKWORTH:

16 Q. So you also got paid fees for consulting?

17 A. Yes.

18 Q. And those fees were paid for consulting
19 with drug companies?

20 A. Yes.

21 Q. Including opioid manufacturers?

22 A. Yes.

23 Q. The honoraria you received for speaking
24 almost always involved conferences that provided
25 continuing medical education credits?

1 A. Yes.

2 Q. And as we just discussed, that's where you
3 would speak to health care providers?

4 A. Yes.

5 Q. Including doctors who would use opioids to
6 treat pain?

7 A. Usually doctors.

8 Q. Usually doctors, correct?

9 A. Correct.

10 Q. And sometimes those speaking engagements
11 were organized directly by a drug company?

12 A. Yes.

13 Q. Sponsored by a drug company?

14 A. Yes.

15 Q. They would -- sometimes the drug companies
16 would pay you?

17 MR. ERCOLE: Objection to form.

18 THE WITNESS: They would provide the
19 honorarium.

20 BY MR. BECKWORTH:

21 Q. Yes. The drug companies would provide the
22 honorarium?

23 A. Yes.

24 Q. They also used something called medical
25 education companies, correct?

1 A. Correct.

2 Q. And when that happened, you would get paid
3 through the medical education company, correct?

4 A. That's correct.

5 Q. And you've remarked that this use of
6 medical education companies to be between the drug
7 company and the speaker is something that increased
8 over your career?

9 A. Yes, I did.

10 Q. What is that?

11 A. Medical education companies are commercial
12 entities that sign contracts with industry partners
13 like the pharmaceutical companies, and they -- and
14 they -- they have different sets of tasks and
15 different expertise.

16 Sometimes they are capable of planning
17 and organizing a conference, getting the speakers,
18 signing the speakers up, providing the speakers with
19 help with transportation and potentially any written
20 materials that go along with the conference.

21 Other medical education companies are --
22 develop programs sponsored by the pharmaceutical
23 companies with payments to them, but those programs,
24 for example, might be online programs that they put
25 on the Internet.

1 So these medical education companies to
2 a much greater extent later in my career than
3 earlier in my career would work with academicians
4 like myself on this kind of programming.

5 Q. And based on your personal experience and
6 knowledge, when medical education companies would do
7 all that, where were they getting the money for it?

8 A. From the pharmaceutical companies that were
9 paying their sponsorship of it.

10 Q. Now, you worked with several different
11 medical education companies in this manner?

12 A. Yes.

13 Q. Did any of them ever come to you and say
14 that they worked exclusively for one drug company
15 manufacturer?

16 MR. ERCOLE: Objection to form.

17 THE WITNESS: I don't have that
18 recollection, no.

19 BY MR. BECKWORTH:

20 Q. None of them ever came to you and said,
21 Look, we're going to have you do a speech for
22 Janssen, and if you do that, you can't ever do work
23 for Purdue, Teva, or Cephalon?

24 MR. ERCOLE: Objection to form.

25 THE WITNESS: That never happened, no.

1 BY MR. BECKWORTH:

2 Q. That never happened?

3 A. No.

4 Q. In fact, these medical education companies,
5 to your knowledge, actually did work for all the
6 defendants in this room?

7 MR. ERCOLE: Objection to form.

8 THE WITNESS: I don't know that. I'm
9 sorry. I can't . . .

10 BY MR. BECKWORTH:

11 Q. Because I'm using a pretty broad term. You
12 understood that certain medical education companies
13 did work for each defendant?

14 MR. ERCOLE: Same objection.

15 THE WITNESS: Yes, certain medical
16 education companies. They were --

17 I should clarify. So there were medical
18 education companies that had a preferred relationship
19 with one or another company. But there were also
20 medical education companies that might be involved
21 with several.

22 BY MR. BECKWORTH:

23 Q. Now, do you know, as you sit here today,
24 which ones have preferred relationships with which
25 companies?

1 A. I'm sorry, it's been so many years, I don't
2 remember any of their names honestly.

3 Q. Now, there are also two types of payments
4 that can be made to your employer Beth Israel,
5 correct?

6 A. Yes.

7 Q. One of those was an educational grant?

8 A. Yes.

9 Q. And that's when a grant of money is done to
10 help develop and implement academic conferences or
11 writing regarding educational materials?

12 MR. ERCOLE: Objection to form.

13 THE WITNESS: So the educational grant
14 might support a conference, it might support a new
15 program, it might support an online educational
16 program. As long as the -- as long as the product,
17 the outcome was educational, it would fall under
18 that mechanism.

19 BY MR. BECKWORTH:

20 Q. The drug companies also paid your employer
21 and institutions like it for something called a
22 research grant?

23 MR. ERCOLE: Objection to form.

24 THE WITNESS: That's correct.

25

1 BY MR. BECKWORTH:

2 Q. Now, in addition to these different types
3 of payments, another way that a person like you and
4 you, yourself got paid was through a consulting fee?

5 A. Yes.

6 Q. Consulting fees occurred when you did
7 things like attended an advisory board?

8 A. Yes.

9 Q. Or assisted a drug company in the
10 development of a research protocol?

11 A. Yes.

12 Q. Educational grants to Beth Israel, your
13 employer for many years, were sometimes paid
14 directly by the drug company?

15 MR. ERCOLE: Objection to form.

16 THE WITNESS: Yes.

17 BY MR. BECKWORTH:

18 Q. And as we established a moment ago, they
19 might also be paid through the vehicle of a medical
20 education company?

21 A. Yes.

22 Q. And, again, when your employer got money
23 from the medical education company, at some point
24 that money was funded by a pharmaceutical company?

25 MR. ERCOLE: Objection to form.

1 THE WITNESS: That's correct. Those
2 dollars would come from the pharmaceutical company
3 to the hospital, and then it would be placed into an
4 account that I would use as chairman to implement
5 the program. Those --

6 BY MR. BECKWORTH:

7 Q. So that money -- sorry.

8 A. I'm sorry. Those dollars could be used to
9 offset salaries that were paid by the hospital for
10 the people who were working on the program. But
11 none of the employees, including myself, received
12 extra money.

13 Q. They could be used to offset salaries?

14 A. They could be.

15 Q. So let's just follow that trail for just a
16 moment if we can. The money from speaking events
17 like this actually went through several stops.

18 Correct me if I'm wrong. It goes from the drug
19 company to a medical education company, correct?

20 A. Yes.

21 Q. Medical education company to the employer
22 hospital?

23 A. Yes.

24 Q. Hospital to whatever its purposes are, that
25 institution, correct?

1 A. I'm not sure how to interpret that.

2 Q. Well, the hospital uses it for whatever the
3 agreement was?

4 A. Whatever the agreement established by the
5 principal of the project, which in the case of my
6 department was usually me.

7 Q. And then that money could also be used to
8 offset the salaries of the folks involved?

9 A. Yes.

10 Q. Now, in addition to all of these
11 different --

12 Sorry. I'll let you put that back.

13 A. Sorry. My apologies.

14 Q. In addition to all of these different types
15 of payments, third-party academic or advocacy groups
16 also got funding from drug companies, correct?

17 A. Correct.

18 Q. And as we discussed, you were with the
19 American Pain Society?

20 A. Yes.

21 Q. It received funding from the drug companies?

22 A. Yes.

23 Q. You were with the American Pain Foundation.
24 It received funding from the drug companies --

25 A. Yes.

1 Q. -- correct?

2 And at some point, the American Pain
3 Foundation stopped getting funding from drug
4 companies, correct?

5 A. Yes.

6 Q. And that's because at some point, the
7 United States Senate did an inquiry into where it
8 was getting its money?

9 A. Yes.

10 MR. ERCOLE: Objection to form.

11 THE WITNESS: I think that was the
12 precipitant, yes.

13 BY MR. BECKWORTH:

14 Q. And after that event, the American Pain
15 Foundation no longer took funding from drug
16 companies?

17 A. Yes. It actually dissolved.

18 Q. Tell the jury why it dissolved.

19 A. Throughout the history -- the American Pain
20 Foundation was set up by some colleagues who were at
21 the American Pain Society, on the board of the
22 American Pain Society, and the American Pain Society
23 felt that it could not handle the requests from the
24 lay population and from patients for information
25 because the American Pain Society is a professional

1 society that caters to the needs of professionals.

2 And there was no entity in the United
3 States that could help consumers and patients get
4 information. So the American Pain Foundation was
5 created in order to try to develop programming that
6 would provide information and support to patients,
7 their families, and the lay population.

8 Throughout the history of the American
9 Pain Foundation, the vast majority of dollars to
10 support programming was acquired through grant
11 writing to the pharmaceutical company -- companies.
12 And this persisted for all of the years of the
13 foundation.

14 There was an effort made on the part of
15 the management of the foundation to expand their
16 access to dollars by applying to foundations, for
17 example. But that was not very successful. So a
18 very large proportion of the American Pain
19 Foundation budget was coming from the pharmaceutical
20 industry.

21 And when the pharmaceutical industry
22 decided they could no longer fund the American Pain
23 Foundation, which temporally took place after the
24 Senate Finance Committee initiated its
25 investigation, there was no more funding for the

1 foundation, and the foundation had to dissolve for
2 lack of budget.

3 Q. That's a lot of information. Thank you.
4 Let's kind of break that down for a moment.

5 The American Pain Foundation was an
6 influential voice in the area of pain treatment in
7 this country?

8 MR. ERCOLE: Objection to form.

9 THE WITNESS: You know, I would qualify
10 that. The American Pain Foundation had no influence,
11 in my mind, on the professional community. But I
12 think it became known among patient advocates as a
13 source of information and support.

14 So it was important in that regard, but
15 it wasn't important to the professional community,
16 physicians, for example.

17 BY MR. BECKWORTH:

18 Q. But to patients it was?

19 A. I believe it was, yes.

20 Q. And you've stated that in at least the
21 treatment of pain using opioids, you think it
22 crosses the line if pharmaceutical makers go direct
23 to the consumer to market advertising, agreed?

24 MR. ERCOLE: Objection to form.

25 THE WITNESS: I agree with that.

1 BY MR. BECKWORTH:

2 Q. You agree that that's improper for a drug
3 company to go straight to a patient and advertise an
4 opioid?

5 MR. ERCOLE: Objection to form.

6 THE WITNESS: I agree with that, yes.

7 BY MR. BECKWORTH:

8 Q. The American Pain Foundation was a voice
9 that provided information to patients and patient
10 advocates, correct?

11 A. Correct.

12 Q. And it received funding from pharmaceutical
13 companies that made opioids?

14 A. That's correct.

15 Q. It depended -- at some point, it depended
16 on those funds to operate?

17 A. That's correct.

18 Q. And in or around 2012, a committee of the
19 United States Senate sent a request for information
20 about the sources of that funding?

21 A. Yes.

22 Q. And at that point in time -- or after that
23 point in time, the American Pain Foundation stopped
24 taking money from pharmaceutical companies that make
25 opioids?

1 A. Yes.

2 Q. And after that, it was no longer able to
3 exist?

4 A. That's correct.

5 Q. Now, you agree that drug companies are a
6 major source of research funding?

7 A. Yes.

8 Q. You agree that this type of funding has the
9 ability to influence study proposals?

10 A. Yes.

11 MR. ERCOLE: Objection to form.

12 BY MR. BECKWORTH:

13 Q. You believe that drug company research
14 grants provided to academics for studies of approved
15 drugs generally fund studies that aim to identify or
16 confirm benefits that will be helpful in marketing?

17 MR. ERCOLE: Objection to form.

18 THE WITNESS: I think that's true, yes.

19 BY MR. BECKWORTH:

20 Q. And by "helpful in marketing," what you
21 mean is it's helpful to the marketing for the drug
22 company that's providing the funding?

23 MR. ERCOLE: Objection to form.

24 THE WITNESS: Yes.

25

1 BY MR. BECKWORTH:

2 Q. And you also believe that drug companies
3 pay honoraria fees and grants in a way that elevates
4 specific messages?

5 A. Yes.

6 MR. ERCOLE: Objection to form.

7 BY MR. BECKWORTH:

8 Q. And you believe that the messengers also
9 get elevated?

10 MR. ERCOLE: Objection to form.

11 THE WITNESS: I'm sorry. I didn't
12 understand that last question. The messengers --

13 BY MR. BECKWORTH:

14 Q. This is because the drug company lawyer is
15 objecting before my question is finished. So let me
16 just ask it again.

17 MR. ERCOLE: Move to strike.

18 MR. BECKWORTH: There's nobody here to
19 strike anything. If you guys will just wait until I
20 finish my question --

21 MR. EHSAN: I would appreciate you not
22 engaging in commentary because you're guessing as to
23 why he couldn't hear your question. If that's not
24 speculation, I'm not quite sure what it is. And I'm
25 pretty sure you're not allowed to speculate.

1 MR. BECKWORTH: You guys, you're going
2 to let me finish my question. This is an Oklahoma
3 jury, a state that I doubt very seriously you guys
4 will step foot in to try this case. But if you do,
5 everyone in that jury box right now, those 12 people
6 who are giving up their time want to hear this
7 gentleman's testimony. And when you step over it so
8 they can't even hear the question, they're going to
9 know that's a drug company lawyer.

10 So here's the deal. Let me finish my
11 question. I'm not going to argue that you waived
12 your objection because you didn't get it started
13 before he talked, okay? That's fair. That's an
14 agreement.

15 MR. EHSAN: No, that's not an agreement.
16 I'm still entitled to object and you're not allowed
17 to put into the record why you think he didn't hear
18 the question. It could have been for lots of
19 reasons.

20 BY MR. BECKWORTH:

21 Q. Sir, you agree that drug companies pay
22 honoraria fees and grants in a way that elevates
23 specific messages and the messengers who agree with
24 the company's preferred messaging?

25 MR. ERCOLE: Objection to form.

1 THE WITNESS: Yes, I do.

2 BY MR. BECKWORTH:

3 Q. Yes, you do?

4 A. Yes, I do.

5 Q. And by "preferred messaging," you're
6 referring to the drug companies' preferred
7 messaging?

8 MR. ERCOLE: Objection to form.

9 THE WITNESS: Yes.

10 BY MR. BECKWORTH:

11 Q. Yes?

12 A. Yes.

13 Q. They're going to just keep doing it, so if
14 you'll let the drug company lawyers object and
15 then --

16 MS. SPENCER: I was going to say, if we
17 could just, you know, put a standing instruction,
18 you know, that the witness will give you the
19 opportunity to ask your question, either the drug
20 companies' attorneys or myself the opportunity to
21 object, and then the witness will start to answer --

22 THE WITNESS: Okay.

23 MS. SPENCER: -- that would probably
24 make this run more smoothly for everyone.

25 MR. BECKWORTH: Yes, sir -- Yes, ma'am.

1 To both of you.

2 BY MR. BECKWORTH:

3 Q. You believe the drug companies used the
4 positive statements that you made about opioids to
5 portray opioid treatment as safe and effective,
6 correct?

7 MR. ERCOLE: Objection to form.

8 THE WITNESS: Yes.

9 BY MR. BECKWORTH:

10 Q. You believe the drug companies used your
11 statements without also using your accompanying
12 discussion of the risk that you included in papers
13 and other things that you wrote, correct?

14 A. Yes.

15 MR. ERCOLE: Objection to form.

16 THE WITNESS: Yes.

17 BY MR. BECKWORTH:

18 Q. Now, based upon your personal knowledge and
19 experience, do you believe that the drug company
20 defendants' research grants to researchers working
21 in academic centers or health care facilities after
22 a drug is approved for marketing almost always align
23 with the drug company defendants' interest in
24 demonstrating the benefits of the drugs they
25 manufacture?

1 MS. SPENCER: Objection to form.

2 THE WITNESS: Yes. The scientific
3 question can be valid, and the scientific question
4 can be of interest to the academician who's doing
5 the research. But the decision to fund the study
6 needs to be consistent with the interests of the
7 company providing the grant.

8 BY MR. BECKWORTH:

9 Q. And that's, in fact, what happened?

10 A. Yes.

11 Q. And you also -- Do you also believe, based
12 upon your same personal knowledge and experience,
13 education, and understanding, that the defendants
14 did this, provided this funding, with the intent of
15 publishing results that could yield higher sales for
16 them in the future?

17 MR. ERCOLE: Objection to form.

18 THE WITNESS: Right. As I said, the
19 scientific question could be valid. It could be of
20 interest to the scientist and the company. It's
21 certainly of interest to the scientist doing the
22 research.

23 But the rationale for the grant will --
24 in my view will include consideration about whether
25 or not the results of the study can be published and

1 help the marketing interests of the company.

2 BY MR. BECKWORTH:

3 Q. The rationale of the grant being the
4 rationale of the defendants who provide the money
5 for the grant?

6 A. Yes.

7 MR. ERCOLE: Objection to form.

8 THE WITNESS: Yes.

9 BY MR. BECKWORTH:

10 Q. Now, based on interactions you've had with
11 medical education vendors, you believe that
12 academics who are provided with honoraria for
13 producing or editing material have to be vigilant in
14 what they do?

15 A. Yes, I do.

16 Q. You believe that they must be vigilant to
17 avoid messages that are not well supported or
18 prudent?

19 A. Yes, I do.

20 Q. And that they must avoid messages that are
21 in the interest of the drug company if they don't
22 have a corresponding medical benefit for patients?

23 A. Yes.

24 Q. You also believe, do you not, that some of
25 your observations are based on your personal

1 interactions with medical education providers over
2 the course of your career?

3 A. Yes.

4 MR. ERCOLE: Objection to form.

5 THE WITNESS: Yes.

6 BY MR. BECKWORTH:

7 Q. What did the medical education vendors do
8 that raised this concern for you?

9 MR. ERCOLE: Objection to form.

10 THE WITNESS: Well, periodically I would
11 receive information to edit for programs that would
12 be supported by the medical education companies with
13 grant support from the industry. And I would have
14 to very carefully edit it to make sure that the
15 messages were scientifically justified and
16 incorporated the proper approach for a physician to
17 address a chronic pain problem.

18 I think that what I was trying to get at
19 there is that physicians who are involved in this
20 sort of work who are -- who are creating programming
21 to educate their colleagues that is supported
22 through grants from the pharmaceutical industry need
23 always to be very careful that everything that they
24 publish over their name, everything that they place
25 on the Internet over their name has been carefully

1 edited to ensure that it's balanced and it includes
2 all the information necessary for safe and
3 appropriate prescribing, which sometimes means that
4 the information needs to be carefully edited because
5 the information that will be received will not have
6 those elements on it -- in it at the start.

7 BY MR. BECKWORTH:

8 Q. And is that because there's competing
9 interests?

10 MR. ERCOLE: Objection to form.

11 THE WITNESS: I couldn't tell you how
12 this all evolves. And I can only tell you that as a
13 physician/educator who receives information that
14 might be of educational value and as an educator
15 that's asked to contribute to that material and make
16 sure that it's appropriate, that requires frequently
17 editing to ensure that the messages are balanced and
18 they're comprehensive and they're appropriate for
19 physicians.

20 BY MR. BECKWORTH:

21 Q. Well, you've also stated, have you not,
22 that some of the work that's ostensibly created by
23 academics in their interactions with medical
24 education company vendors will actually reflect the
25 work or influence of the pharmaceutical industry?

1 MR. ERCOLE: Objection to form.

2 THE WITNESS: Yes, I believe that that's
3 true.

4 BY MR. BECKWORTH:

5 Q. So you have to be very careful to make sure
6 that doesn't happen?

7 MR. ERCOLE: Objection to form.

8 THE WITNESS: I agree that's true.

9 BY MR. BECKWORTH:

10 Q. But no matter what, it's happened?

11 A. I believe that's true, yes.

12 Q. And when you used the word "ostensibly," as
13 I understand that, do you mean that the work looks
14 like it's the work of the academic, but it actually
15 has the influence of the pharmaceutical industry?

16 MR. ERCOLE: Objection to form.

17 THE WITNESS: Yes.

18 BY MR. BECKWORTH:

19 Q. And when that happens, that's a bad thing?

20 MR. ERCOLE: Objection to form.

21 THE WITNESS: Yes, that's a bad thing.

22 BY MR. BECKWORTH:

23 Q. It can be misleading?

24 A. Yes.

25 Q. And as we established earlier, medical

1 education companies like this, they get hired by the
2 drug companies?

3 A. Yes.

4 Q. Including the defendants here?

5 MR. ERCOLE: Objection to form.

6 THE WITNESS: Yes.

7 BY MR. BECKWORTH:

8 Q. Your answer was yes, including the
9 defendants here?

10 A. Yes.

11 Q. Now, based upon your personal experience,
12 you know that the speaker programs were used by
13 these defendants to help them sell opioids?

14 MR. ERCOLE: Objection to form.

15 THE WITNESS: I don't have personal
16 information about that as a stated aim of these
17 programs. So I'm not -- maybe I could ask you to be
18 more specific in what you're asking me.

19 BY MR. BECKWORTH:

20 Q. The drug company defendants here use
21 speaker programs, correct?

22 A. Correct.

23 Q. And part of their purpose as you understand
24 it based on your personal experience is to help them
25 sell more drugs?

1 MR. ERCOLE: Objection to form.

2 THE WITNESS: What I would say is that
3 the speaker programs had the primary objective to
4 educate doctors, but the messages that doctors would
5 give when giving talks for the speakers bureaus
6 would generally favor the drugs provided -- created
7 by those drug companies.

8 MR. COLEMAN: That's all right.

9 MR. BECKWORTH: No. I'm going to wait
10 until you stop rudely interrupting the deposition.
11 Are you done?

12 MR. COLEMAN: Done.

13 MR. BECKWORTH: Thank you. All right,
14 sir, I'm going to hand you a document marked
15 Exhibit 3. This is a document produced by Janssen
16 that is called the "Nucynta and Nucynta ER 2012
17 Business Plan."

18 (Portenoy Exhibit 3 was marked
19 for identification.)

20 MR. BECKWORTH: I'll hand that to you.

21 THE WITNESS: Yes.

22 MR. BECKWORTH: Hand that to each of
23 you.

24 BY MR. BECKWORTH:

25 Q. Feel free to look through that. I'm going

1 to turn your attention to just a couple parts. You
2 understand that Nucynta and Nucynta ER are opioids
3 that Janssen put out, right?

4 A. Yes.

5 Q. If you'll turn to page 2 of this document,
6 which is a PowerPoint, it lists "Objectives."

7 Do you see that?

8 A. Yes.

9 Q. And one of these objectives it says is
10 "Review and gain alignment on 2012 tactics that
11 support identified strategic imperatives"?

12 A. Yes.

13 Q. And then you see on the next page it says
14 "2012 Business Plan"?

15 A. Yes.

16 Q. Now, if you'll look through this, the very
17 next page, page 4, looks at a chart of Nucynta
18 prescriptions and a forecast over the next year.

19 Do you see that?

20 A. Yes.

21 MR. ERCOLE: Objection to form.

22 THE WITNESS: Yes.

23 BY MR. BECKWORTH:

24 Q. Now, if you'll turn, sir, to page 8, take a
25 look at that for just a second. Now, page 8 of

1 Exhibit 4 -- I believe it's 4 -- of Exhibit 3 --
2 page 8 of Exhibit 3 has a box there that's titled:
3 "What we've learned from our customers (market
4 research: Second Q 2011)," correct?

5 A. Yes.

6 MR. ERCOLE: Objection to form.

7 BY MR. BECKWORTH:

8 Q. And at the bottom it has a box that says
9 "Nucynta selling efforts," correct?

10 A. Yes.

11 Q. I know you've never seen this Janssen
12 document before, but could you read the first bullet
13 point there.

14 MR. ERCOLE: Objection to form.

15 THE WITNESS: "Highly promotionally
16 sensitive."

17 BY MR. BECKWORTH:

18 Q. Then what does it say under that?

19 A. "Speaker programs often trigger first use."

20 Q. Referring to Nucynta?

21 A. Yes.

22 Q. A drug that Janssen sold?

23 A. Yes.

24 Q. Now, if you will turn, please, to page 10,
25 there's another box there, and it says, "Nucynta's

1 success requires integrated efforts across
2 stakeholders within their sites of care," correct?

3 A. Yes.

4 Q. And then if you look therein, it lists
5 "Prescribers," correct?

6 A. Yes.

7 Q. "Payers"?

8 A. Yes.

9 Q. And "Influencers"?

10 A. Yes.

11 Q. And then it lists "Sites of care," right?

12 A. Yes.

13 Q. Right along with prescribers, in the
14 "Influencers" box, it lists several other types of
15 stakeholders, correct?

16 A. Yes.

17 Q. And one of those is "Professional and
18 patient advocacy," right?

19 A. Yes.

20 Q. Have you ever seen a document like this?

21 A. I have not seen this document, no.

22 Q. Were you aware that Janssen viewed the work
23 of speaker bureaus as part of its sales program?

24 MR. EHSAN: Object to form.

25 THE WITNESS: No. I wasn't aware of

1 that.

2 BY MR. BECKWORTH:

3 Q. Were you aware that Janssen knew that the
4 first use of an opioid could be triggered by
5 speakers that they paid to go out and speak in this
6 way?

7 A. I wasn't --

8 MR. EHSAN: Object to form.

9 THE WITNESS: I wasn't aware of that,
10 no.

11 BY MR. BECKWORTH:

12 Q. But it certainly supports what you've
13 testified to already: that you understand that the
14 speaker programs that drug companies like Janssen
15 used were done to help them sell more drugs?

16 MR. EHSAN: Objection to form.

17 MR. ERCOLE: Objection to form.

18 THE WITNESS: Yes, that's correct.

19 BY MR. BECKWORTH:

20 Q. They objected, but it's true, isn't it?

21 MR. EHSAN: Same objection.

22 THE WITNESS: Yes.

23 BY MR. BECKWORTH:

24 Q. Do you have a guess why they're objecting?

25 MR. EHSAN: Objection to form.

1 THE WITNESS: I don't have a guess, no.

2 BY MR. BECKWORTH:

3 Q. Well, you just said that Janssen had an
4 intent to use speaker programs to help it get its
5 product used?

6 MR. EHSAN: Object to form.

7 THE WITNESS: I did, yes.

8 BY MR. BECKWORTH:

9 Q. And that supports your statement regarding
10 that in your declaration?

11 A. Yes.

12 Q. Now, let me show you the next one, sir.
13 Are you familiar with a drug called Duragesic?

14 A. Yes.

15 Q. You understand that was a fentanyl product?

16 A. Yes.

17 Q. An opioid?

18 A. Yes.

19 Q. A Janssen product?

20 A. Yes.

21 (Portenoy Exhibit 4 was marked
22 for identification.)

23 BY MR. BECKWORTH:

24 Q. I'm going to hand you Exhibit 4, please.
25 You've never seen this document before?

1 A. No, I have not.

2 Q. We'll go through certain parts of it. And
3 if there's anything I ask you that you need to read
4 further, just let me know.

5 This document starts by saying, with
6 respect to Duragesic, "Coming off a record-breaking
7 year of \$543 million in 2001, the bar has been
8 raised for Duragesic in 2002 to \$692 million in
9 sales, a 28 percent increase."

10 Do you see that?

11 A. Yes.

12 Q. If you go down two sentences, it says,
13 "You are our primary sales force that drives nearly
14 75 percent of the business through pain specialist
15 and primary care physicians."

16 It says that, doesn't it?

17 A. Yes.

18 Q. And it says, "Over the past year, we have
19 made considerable progress growing our market share
20 with this audience"?

21 A. Yes.

22 Q. Now, it goes down on the bold part that
23 says "Market update."

24 Do you see that?

25 A. Yes.

1 Q. It says, "Market growth has slowed in the
2 first half of 2002 and our need to focus on taking
3 market share from OxyContin by selling head to
4 head."

5 Do you see that?

6 A. I do, yes.

7 Q. So we're talking about Duragesic used in
8 reference to taking market share from OxyContin?

9 A. Yes.

10 Q. Now, Duragesic's a fentanyl patch?

11 A. Yes.

12 Q. OxyContin's a pill?

13 A. Yes.

14 Q. Duragesic's made by Janssen?

15 A. Yes.

16 Q. OxyContin, name brand made by Purdue?

17 A. Yes.

18 Q. And generic versions sold by Cephalon/Teva?

19 MR. ERCOLE: Objection to form.

20 THE WITNESS: I don't know that.

21 BY MR. BECKWORTH:

22 Q. You know there's generic versions of
23 OxyContin?

24 A. Yes.

25 Q. Now, if we go to "Strategic focus" here for

1 this sales effort, you see something called
2 "Physician target: Call plan attachment" --
3 "attainment/impactful message delivery."

4 Do you see that?

5 A. Yes.

6 Q. At the bottom of that it says, "Success
7 means increasing Duragesic share at the expense of
8 OxyContin with all of our targeted physicians, not
9 just concentrating on the highest-deciled targets."

10 Do you see that?

11 A. I do, yes.

12 Q. Now, did you know that Janssen referred to
13 health care providers as targets?

14 MR. EHSAN: Object to form.

15 THE WITNESS: I didn't know.

16 BY MR. BECKWORTH:

17 Q. Did you know that during the internal sales
18 process that Janssen and Purdue and Teva used that
19 they referred to the doctors they interfaced with as
20 targets?

21 MR. ERCOLE: Objection to form.

22 THE WITNESS: I did not know.

23 BY MR. BECKWORTH:

24 Q. Did you know that they deployed their sales
25 force to go talk to doctors that were identified

1 literally as targets?

2 MR. ERCOLE: Objection to form.

3 THE WITNESS: I knew that they deployed
4 their sales force to talk to doctors, not that they
5 labeled the doctors as targets.

6 BY MR. BECKWORTH:

7 Q. Did you know that they referred to the
8 sales process of going to targets as something
9 called detailing?

10 A. Yes.

11 Q. Did you know that these companies obtained
12 prescription data through something called IMS where
13 they could tell the prescribing habits of every
14 doctor that they called upon?

15 MR. ERCOLE: Objection to form.

16 THE WITNESS: Yes. Yes, I knew.

17 BY MR. BECKWORTH:

18 Q. And did you know that they then took that
19 data to rank their sales targets based on whether
20 the target was likely to prescribe their drug?

21 MR. ERCOLE: Objection to form.

22 THE WITNESS: Yes, I know that went on.
23 Yes.

24 BY MR. BECKWORTH:

25 Q. And did you know that these companies

1 ranked those doctors based on something called their
2 value, meaning that if they ranked high enough as a
3 likely candidate to prescribe, then they were worthy
4 of the time, money, and effort it took to go call
5 upon them?

6 MR. ERCOLE: Objection to form.

7 THE WITNESS: I didn't know that
8 specific -- that level of specificity.

9 BY MR. BECKWORTH:

10 Q. You've been around a lot of doctors,
11 haven't you?

12 A. Yes.

13 Q. You've been around primary care physicians?

14 A. Yes.

15 Q. Do you think based on your personal
16 experience, training, your life's work in the pain
17 space, that your average primary care physician
18 knows that when a sales rep comes to them, they are
19 being referred to as a target?

20 MR. ERCOLE: Objection to form.

21 MS. SPENCER: Objection. He can only
22 answer what he knows.

23 BY MR. BECKWORTH:

24 Q. And I'm asking you based on your personal
25 experience with primary care physicians that you

1 know.

2 MR. ERCOLE: Same objection.

3 MS. SPENCER: You may answer.

4 THE WITNESS: I don't think they would
5 know that they're being labeled as a target, no.

6 BY MR. BECKWORTH:

7 Q. Now, here it also says a "Patient target:
8 Expand Duragesic use in nonmalignant pain," correct?

9 A. Yes.

10 Q. And for the benefit of the jury -- which
11 I'm sure everyone here understands -- there's a
12 difference in pain treatment between malignant, or
13 cancer, pain and then noncancer pain, right?

14 MR. ERCOLE: Objection to form.

15 THE WITNESS: There is a difference, but
16 I would just like to clarify this because it's a
17 very important point.

18 BY MR. BECKWORTH:

19 Q. Sure.

20 A. Specifically relevant to palliative care.
21 Cancer pain is pain related specifically to a
22 cancer, usually metastatic disease.

23 Patients who have other types of
24 advanced medical illness are often considered to be
25 appropriate for treatment as if they have cancer

1 pain. So a patient who has very advanced heart
2 failure or very advanced multiple sclerosis might
3 have very severe pain and is considered by the
4 medical community to be comparable to cancer pain,
5 especially by the palliative care community who
6 views those patients to be essentially identical to
7 those patients with cancer pain.

8 Usually and particularly at this time
9 when the term "noncancer pain" or "nonmalignant
10 pain" was used, it was referring to very large
11 populations with chronic musculoskeletal-type pains,
12 like low back pain, chronic neck pain, fibromyalgia,
13 myofascial pain, and headache.

14 Q. Make sure that is correct. The nonmalignant
15 pain, as you're referring to these very large
16 chronic neck pain, fibromyalgia and the like?

17 A. That's correct.

18 MR. ERCOLE: Objection to form.

19 BY MR. BECKWORTH:

20 Q. And if you look here just below the last
21 paragraph of this document we were reading, it says,
22 "Our objective is to convince physicians that
23 Duragesic is effective and safe to use in moderate
24 to severe chronic pain such as back pain and
25 degenerative joint disease like osteoarthritis,"

1 correct?

2 A. Yes.

3 Q. And that's what you're talking about:

4 nonmalignant, non-palliative --

5 A. That is correct.

6 Q. Now, you see what I see, right? Who is

7 their target?

8 A. Physicians.

9 Q. And it says, Our objective is to do

10 something with respect to physicians. What word did

11 Janssen use?

12 A. I'm not sure what you mean by the question.

13 I'm sorry.

14 Q. If you'll look to the third line there in

15 that paragraph, it says, "objective is to"?

16 A. "Convince physicians that Duragesic is

17 effective and safe to use in moderate to severe

18 chronic pain such as back pain and degenerative

19 joint disease like osteoarthritis."

20 Q. And the choice they used in this document

21 to their sales force is the word "convince"?

22 A. Yes.

23 Q. Convince who?

24 A. The physician.

25 Q. So if you'll turn to the next page, please.

1 You'll see it says something called -- well, at the
2 first full paragraph there, the first sentence says,
3 "Based on extensive market research, we have
4 enhanced our current promotional message to maximize
5 our product benefits and address relevant issues
6 among chronic pain physicians."

7 Do you see that?

8 A. Yes.

9 Q. And there right below it in bold it says,
10 "Sales materials/programs - new this cycle,"
11 correct?

12 A. Yes.

13 Q. And if you go down, there's one that says
14 "Nonpersonal selling/no rep involvement." And it
15 lists a newsletter and a direct mail program.

16 Do you see that?

17 A. Yes.

18 Q. Let's turn to the next page. There's
19 another thing listed with respect to the sales
20 effort about convincing doctors, isn't there?

21 A. Yes.

22 Q. It's "Medical education/no rep
23 involvement"?

24 A. That's correct.

25 Q. And there it lists something that says

1 "National Pain Education Council (NPC)" -- excuse
2 me -- "(NPEC) invitation."

3 Do you see that?

4 A. Yes.

5 Q. And lists an audience. Who is the
6 audience?

7 A. "Primary care, pain specialties,
8 oncologists, residents, nurses, pharmacists."

9 Q. And in this sales effort to use NPEC,
10 there's a description of how to do it. Will you
11 read that for the jury where it says "Description."

12 A. Yes. "National Pain Education Council is
13 funded by an educational grant from Janssen.
14 Invitation to participate in a multimedia CME
15 program for physicians and other medical
16 professionals on the appropriate opioid
17 pharmacotherapy for chronic pain management.
18 Announcement invites medical professionals to visit
19 www.npecweb.org website."

20 Q. Now, you were involved in the NPEC at some
21 point, correct?

22 A. Yes.

23 Q. Tell the jury what that was, please, sir.

24 A. I believe that I was the cochair of NPEC --
25 of the NPEC initiative.

1 Q. And that was a CME, continuing medical
2 education, platform, correct?

3 A. That's correct.

4 MR. ERCOLE: Objection to form.

5 BY MR. BECKWORTH:

6 Q. And it was funded in part by Janssen?

7 A. I think it was funded -- to my
8 recollection, I think it was funded entirely by
9 Janssen.

10 Q. And so did you know that, in internal
11 documents about selling Duragesic, that Janssen
12 intended to use that platform this way?

13 A. No, I did not.

14 Q. Does it trouble you to know that now?

15 MR. EHSAN: Object to form.

16 THE WITNESS: It does, yes.

17 BY MR. BECKWORTH:

18 Q. Why does it trouble you?

19 A. The platform was a CME platform. And
20 continuing medical education is supposed to be based
21 on information that's balanced and comprehensive and
22 medically appropriate.

23 At best, there is a firewall between
24 continuing medical education and marketing. That
25 firewall has gotten a lot stronger in recent years

1 because of the recognition that things like this
2 were happening. But this, to me, demonstrates why
3 the firewall was necessary, why the rules have
4 gotten much stronger.

5 Because continuing medical education
6 programming, which was not intended by -- for
7 marketing purposes and certainly the academic people
8 who were devoting their energies to it were not
9 considering themselves as contributing to marketing
10 in any way, was actually being used by the company
11 as a marketing strategy.

12 BY MR. BECKWORTH:

13 Q. So let's go back through that real quickly
14 because there's some important parts to it. There
15 were three entities listed there, right? There are
16 the people that attend these engagements, right?

17 A. Yes.

18 Q. Then there's the people that are lecturing
19 or speaking at them, correct?

20 A. Yes.

21 Q. And then there's the drug company, which in
22 this case is Janssen, right?

23 A. Yes. And --

24 Q. Of the three, two of them had no idea that
25 Janssen internally was using this platform as a way

1 to sell its drugs to doctors?

2 MR. ERCOLE: Object to form.

3 MR. EHSAN: Objection to form.

4 THE WITNESS: Well, certainly I can't
5 speak to whether physicians who attended would know
6 or not. But I can speak for myself. And I didn't
7 know. And I was the cochair of the program.

8 BY MR. BECKWORTH:

9 Q. They didn't tell you?

10 A. No. No, no, no.

11 Q. That's troubling?

12 MR. EHSAN: Object to form.

13 THE WITNESS: Yes.

14 BY MR. BECKWORTH:

15 Q. Because you -- we talked about this earlier
16 when one person can't do something alone, you're
17 giving your work to do this, and the funding's being
18 paid by Janssen, right?

19 A. Yes.

20 MR. ERCOLE: Objection to form.

21 BY MR. BECKWORTH:

22 Q. And internally they're talking about going
23 at a competitor to increase the profile of a
24 fentanyl opioid drug?

25 A. Yes.

1 MR. ERCOLE: Objection to form.

2 BY MR. BECKWORTH:

3 Q. That's a serious Schedule II narcotic?

4 MR. ERCOLE: Same objection.

5 THE WITNESS: I'm not sure how to
6 interpret that last comment. But I'll endorse the
7 concept -- I'll endorse the conclusion that as an
8 academic who was trying to educate professionals and
9 whose messages about benefit and risk had always
10 been part of that educational programming from the
11 very first time that I started it, that was the goal
12 of this involvement in NPEC, was to provide
13 information of that type.

14 And there was no understanding on my
15 part that it would be used in some way as a
16 marketing strategy.

17 BY MR. BECKWORTH:

18 Q. And, in fact, they also didn't share with
19 you -- "they" being Janssen in this instance -- that
20 they had internal survey data that showed that
21 speaker bureaus and conferences like this actually
22 help them sell more drugs?

23 MR. ERCOLE: Objection to form.

24 THE WITNESS: No. I don't have any
25 recollection that that was ever shared with me.

1 BY MR. BECKWORTH:

2 Q. You would have liked to have known that?

3 A. No. It wasn't my area of interest. I had
4 no desire with any of these engagements, these
5 initiatives that I did with the drug company
6 funding, in my mind, this was very important to keep
7 separate from any marketing interest.

8 My interest was education of
9 professionals, and the messages had to be
10 comprehensive, they had to be balanced, and they had
11 to be accurate, scientifically accurate.

12 Q. That's right. That's what was in your
13 mind, but that's not what's in these documents?

14 MR. EHSAN: Objection to form.

15 MR. ERCOLE: Object to form.

16 THE WITNESS: That's true.

17 BY MR. BECKWORTH:

18 Q. They didn't tell you about it?

19 A. No, they did not.

20 Q. And that was deceptive to you?

21 MR. EHSAN: Object to form.

22 THE WITNESS: I wish that I had known.

23 BY MR. BECKWORTH:

24 Q. So I just want to clean up a few questions
25 that I had. When you talked about opioids for

1 advanced illnesses, you're aware, aren't you, that
2 most patients on long-term opioids do not have pain
3 from advanced illnesses like multiple sclerosis?

4 A. Yes.

5 MR. ERCOLE: Objection to form.

6 BY MR. BECKWORTH:

7 Q. You agree with me?

8 A. Yes.

9 Q. You also would agree that most patients on
10 long-term opioids have common conditions like low
11 back pain, chronic headache, and fibromyalgia?

12 MR. ERCOLE: Objection to form.

13 THE WITNESS: Yes.

14 BY MR. BECKWORTH:

15 Q. Now, we were also talking about the Senate
16 Finance investigation into third-party groups?

17 A. Yes.

18 Q. And the funding they received; do you
19 remember that?

20 A. Yes.

21 Q. Now, do you recall as being involved with
22 APF and APS that there were investigative journal
23 articles that were written prior to the Senate
24 Finance Committee that called into question whether
25 these groups should be receiving funds from

1 pharmaceutical companies?

2 MR. ERCOLE: Objection to form.

3 THE WITNESS: I'm not sure what you mean
4 by "investigative journal articles."

5 BY MR. BECKWORTH:

6 Q. Well, newspaper/magazine folks.

7 A. Oh, in the lay press?

8 Q. Yes.

9 A. Yes.

10 Q. And you understand they were raising
11 questions about this?

12 A. Yes.

13 MR. ERCOLE: Same objection.

14 BY MR. BECKWORTH:

15 Q. And you understand, based on your own
16 experience, that after those questions started being
17 asked, there was a Senate inquiry?

18 A. Yes.

19 MR. ERCOLE: Objection to form.

20 BY MR. BECKWORTH:

21 Q. Let's kind of turn your attention to a few
22 other deals. We were talking about how --

23 MS. SPENCER: A point of clarification.

24 Are we on P4 or are we done with P4?

25 MR. BECKWORTH: I'm done with it for

1 now.

2 BY MR. BECKWORTH:

3 Q. Now, you stated in your declaration you've
4 been at MJHS since 2014?

5 A. Yes.

6 Q. Since that time, y'all haven't -- you
7 haven't taken consultation fees from the
8 pharmaceutical industry?

9 A. No.

10 Q. You listed, I think, one exception where
11 you've been involved in a research grant?

12 A. Yes.

13 Q. Why are you no longer taking these types of
14 fees from these defendants?

15 MR. ERCOLE: Objection to form.

16 THE WITNESS: Well, there's really two
17 reasons for that. And one reason is that my current
18 role is devoted entirely to palliative care. And so
19 I haven't really been asked to participate much in
20 pain education, opioid education.

21 The second reason is that I've been
22 turning down any opportunities that have existed
23 because of the litigation that's going on and my
24 concern about how that would play out.

25

1 BY MR. BECKWORTH:

2 Q. And since you got named in various lawsuits
3 around the country, have any of the defendants in
4 this case come to you and asked you to do work for
5 them?

6 MR. ERCOLE: Objection to form.

7 THE WITNESS: I don't believe so, no.

8 BY MR. BECKWORTH:

9 Q. Not since the lawsuits got filed?

10 A. Not that I think -- not that I remember, no.

11 Q. Thank you. Now if you want to turn to your
12 declaration in paragraph 30, it might help you.
13 I'm going to go through some of the payments that
14 you list there.

15 A. Um-hum.

16 Q. In paragraph 30 of your declaration, sir,
17 you list partial payments that you've received,
18 correct?

19 A. Yes.

20 Q. And you state that this is the best of your
21 recollection based on the documents you have,
22 correct?

23 A. Correct.

24 Q. You admit this list isn't everything?

25 A. Yes.

1 Q. And I just want you to know, I'm going to
2 go over some other things that we found. It's not
3 saying "I got you." I understand that you've
4 provided what you knew, and then we've looked
5 through records, and I'll give you the opportunity
6 to look at other things, okay?

7 A. Yes.

8 MR. ERCOLE: Objection to form.

9 BY MR. BECKWORTH:

10 Q. Now, you were paid, as we discussed, to
11 speak at CMEs and annual conferences where drug
12 company funding provided those resources?

13 A. Yes.

14 Q. Often -- Well, let me ask you this. Was it
15 often the time or the case that when you did that,
16 it was unbranded?

17 MR. ERCOLE: Objection to form.

18 THE WITNESS: I need you to clarify what
19 you mean by the word "unbranded."

20 BY MR. BECKWORTH:

21 Q. So let's use the example we just gave.
22 When Janssen would provide funding for you that
23 internally they viewed as good for sales, they
24 wouldn't go and have you, say, promote specific
25 drugs like Duragesic or Nucynta?

1 MR. EHSAN: Objection to form, move to
2 strike.

3 THE WITNESS: That's correct. I never
4 gave a talk that was specifically intended to
5 promote any drug.

6 BY MR. BECKWORTH:

7 Q. Right. Your talks were about treating
8 pain, and one of the ways to do that in the
9 noncancer palliative care space is using opioids?

10 MR. ERCOLE: Objection to form.

11 THE WITNESS: That's correct.

12 BY MR. BECKWORTH:

13 Q. And your work was to talk about and
14 increase attention to using opioids as one of those
15 treatment mechanisms?

16 MR. ERCOLE: Objection to form.

17 THE WITNESS: That's correct, yes.

18 BY MR. BECKWORTH:

19 Q. And so when you spoke in the ways that
20 we've talked about, it was done in a way that was
21 not drug-specific, correct?

22 A. Yes.

23 Q. But it often talked about -- or you often
24 talked about using opioids just generally as they
25 might apply to different types of modalities?

1 MR. ERCOLE: Objection to form.

2 THE WITNESS: That's true.

3 BY MR. BECKWORTH:

4 Q. Now, in this list, you state that -- we're
5 just going to go down it -- from November 30 to
6 December 1, 2006, you consulted for an advisory
7 board for Alpharma for the drug Kadian, which is now
8 distributed by Allergan, correct?

9 A. Yes.

10 Q. You were paid \$3,030?

11 A. Yes.

12 Q. In 2007, you worked on a multicenter
13 clinical trial for a drug company called Endo,
14 correct?

15 A. Yes.

16 Q. Your employer was paid \$8,880 for that?

17 A. Yes.

18 Q. On February 19, 2007, you participated in a
19 seminar called the: Breakthrough pain curriculum
20 development workshop"?

21 A. Yes.

22 Q. And you were paid \$3,000?

23 A. Yes.

24 Q. You were paid on that by Advanced
25 Strategies in Medicine, correct?

1 A. Yes.

2 Q. And that's one of these medical education
3 companies?

4 A. That's correct.

5 Q. But you understand that was actually
6 financed by Cephalon related to its opioid drug
7 Fentora?

8 A. Yes.

9 MR. ERCOLE: Objection to form.

10 THE WITNESS: Yes.

11 BY MR. BECKWORTH:

12 Q. On May 15, 2007, you were paid \$3,500 for
13 working on an advisory board for Cephalon, again
14 related to its opioid Fentora?

15 A. Yes.

16 Q. On November 6, 2007, you presented a
17 continuing medical education program called "Meet
18 the patients: Individualizing therapy for persistent
19 and breakthrough pain"?

20 A. Yes.

21 Q. Correct? You were compensated \$2,000?

22 A. Yes.

23 Q. And, again, you were paid by Advanced
24 Strategies in Medicine?

25 A. Yes.

1 Q. And, again, you believe that was actually
2 paid through Cephalon related to its Fentora
3 product?

4 A. Yes.

5 MR. ERCOLE: Objection to form.

6 BY MR. BECKWORTH:

7 Q. Yes?

8 A. Yes.

9 Q. 2008, you entered into a consulting
10 agreement with Insys for the purpose of product
11 development?

12 A. Yes.

13 Q. Insys paid you at a rate of \$500 per hour?

14 A. Yes.

15 Q. In 2008, you entered into an advisory board
16 agreement with Endo for purposes of product
17 development?

18 A. Yes.

19 Q. And Endo paid you \$2,500?

20 A. Yes.

21 Q. You also contracted with something called
22 Miller Medical Communications to present a
23 continuing medical education program in Brooklyn,
24 New York on October 30, 2009, correct?

25 A. Yes.

1 Q. And that was called "When opioids are
2 indicated for chronic pain: How to optimize
3 therapeutic outcomes and minimize risk"?

4 A. Yes.

5 Q. Now, that one was sponsored by King
6 Pharmaceuticals and Purdue Pharma, right?

7 A. Yes.

8 Q. You got paid \$2,000?

9 A. Yes.

10 Q. December 16, 2009, you entered into a
11 two-year master health care professional consultant
12 services agreement with Purdue?

13 A. Yes.

14 Q. That same day you entered into a statement
15 of work indicating that the purpose of the agreement
16 "was to provide expert opinion regarding new product
17 opportunities, products currently under development,
18 areas of unmet medical need, and the clinical
19 application/implications of new Purdue products"?

20 A. Yes.

21 Q. You believe that that Purdue agreement
22 concerned the opioid Butrans?

23 A. Yes.

24 Q. Purdue paid you a total of \$40,000 plus
25 expenses for your work on that project?

1 A. Yes.

2 Q. Now, during this time frame while you were
3 receiving income from these drug companies for the
4 work we listed, as we discussed, you were advocating
5 for pain treatment to be done, and consider the use
6 of opioids to treat chronic pain that was neither
7 malignant nor palliative?

8 MR. ERCOLE: Objection to form.

9 THE WITNESS: Yes. I was teaching about
10 that extensively, and writing about it.

11 BY MR. BECKWORTH:

12 Q. There's no secret that that's something you
13 wrote about?

14 A. Yes.

15 Q. And that you talked about?

16 A. Yes.

17 Q. Now, during many of these years, you worked
18 for the hospital Beth Israel, correct?

19 A. Yes.

20 MR. BECKWORTH: I'm going to hand you
21 what we'll mark as Exhibit 5.

22 (Portenoy Exhibit 5 was marked
23 for identification.)

24 BY MR. BECKWORTH:

25 Q. I'll give you a copy, and if you'll pass

1 the others to your lawyer, please.

2 Sir, while you look through that,
3 Exhibit 5 is a document called "Department of Pain
4 Medicine and Palliative Care 1997 through 2007."

5 Do you see that?

6 A. Yes.

7 Q. And this document --

8 MS. SPENCER: Can he have a moment to
9 review the document?

10 MR. BECKWORTH: Absolutely.

11 MS. SPENCER: Thank you.

12 THE WITNESS: Okay.

13 BY MR. BECKWORTH:

14 Q. This document is announcing an anniversary
15 fund and seeking funding?

16 A. Yes.

17 Q. If you'll turn to page 5 in this document,
18 it lists the DPMPC's philanthropic partners from
19 1997 through 2007.

20 MS. SPENCER: I'm not sure if the
21 witness's copy is out of order, but my copy is out
22 of order. Could we take a minute and reorder the
23 pages so that they're . . .

24 MR. BECKWORTH: You certainly can do
25 that. The page that I -- the only page I'm going to

1 ask questions about is --

2 MS. SPENCER: The one that's marked
3 page 5 or the fifth page?

4 MR. BECKWORTH: -- marked page 5.

5 MS. SPENCER: That was my confusion.
6 Thank you.

7 MR. BECKWORTH: We'll straighten that
8 exhibit up.

9 MS. SPENCER: I apologize.

10 MR. BECKWORTH: And the Bates is 5838,
11 for clarification.

12 MS. SPENCER: That's correct. Thank
13 you.

14 BY MR. BECKWORTH:

15 Q. This document lists money that's been
16 provided to DPMPC from '97 up through June 15, 2007,
17 correct?

18 MR. ERCOLE: Object to form.

19 THE WITNESS: Yes.

20 BY MR. BECKWORTH:

21 Q. For the benefit of the jury, can you tell
22 us what DPMPC is.

23 A. The acronym stands for Department of Pain
24 Medicine and Palliative Care. That was the
25 department that I chaired at Beth Israel Medical

1 Center for a 15-year period, '97 through 2014.

2 Q. Now, there's a lot of folks and entities
3 listed here, correct?

4 A. Yes.

5 Q. Let's go to the first one. In the
6 \$1 million and up category, who is listed?

7 A. Endo Pharmaceuticals.

8 Q. Now, also in that category is Pfizer?

9 A. Yes.

10 Q. If you'll go to the \$500,000 to \$999,999
11 category, the first one listed is Abbott
12 Laboratories?

13 A. Yes.

14 Q. Then we see Cephalon, Inc.?

15 A. Yes.

16 Q. And Janssen Medical Affairs?

17 A. Yes.

18 Q. If you go to the \$100,000 to \$499,000
19 [sic], we see Russell Portenoy, M.D.?

20 A. Yes.

21 Q. Did you provide donations to DPMPC out of
22 your own pocket?

23 A. Periodically during this period, I would do
24 consulting work or speak, and I would transfer my
25 honorarium or my speaking -- my fee, my consulting

1 fee to the department to support the department's
2 activities and the salaries of my colleagues.

3 Q. So those donations from you would be --
4 I don't mean this in a legal term -- but would be
5 passed through from a payment for a speech to you
6 and then you would take it --

7 MR. ERCOLE: Objection --

8 BY MR. BECKWORTH:

9 Q. -- and donate it to the entity?

10 THE WITNESS: Yes.

11 MR. ERCOLE: Objection.

12 BY MR. BECKWORTH:

13 Q. You understand what I'm asking?

14 MR. ERCOLE: Objection to form.

15 BY MR. BECKWORTH:

16 Q. Is that correct?

17 A. That's correct.

18 Q. So if we go -- right below you, we see
19 Purdue Pharma, L.P., correct?

20 A. Yes.

21 Q. In the \$50,000 to \$999,000 [sic] category,
22 we have Alpharma Pharmaceuticals?

23 A. Yes.

24 Q. And at the bottom we have Ortho-McNeil
25 Pharmaceutical, correct?

1 A. That's correct.

2 MR. ERCOLE: Objection to form.

3 Incomplete statement of all the people listed. But
4 go ahead.

5 BY MR. BECKWORTH:

6 Q. You understand that I'm going through and
7 listing certain ones?

8 A. Yes.

9 Q. And the document will speak for itself
10 about who else may be listed?

11 A. Yes.

12 Q. And if we go to the \$5,000 to \$9,900 [sic]
13 side of this on the right, one of the entities is
14 King Pharmaceuticals?

15 A. Yes.

16 Q. One of them is Eli Lilly and Company,
17 correct?

18 A. Yes.

19 Q. There's quite a few drug companies listed?

20 A. That's right.

21 Q. And we at least have a Janssen entity, a
22 Purdue entity, and a Cephalon entity listed here,
23 correct?

24 A. Yes.

25 Q. Now, during the time that you were working

1 for Beth Israel, what was your average total
2 compensation?

3 A. I don't have a clear recollection of this.
4 I think it was probably -- probably around \$350,000.

5 Q. Were you the highest paid person there?

6 A. In the hospital?

7 Q. Yes.

8 A. Oh, no.

9 Q. The highest paid person in the department
10 that you chaired?

11 A. Yes.

12 Q. And on your total compensation you just
13 listed and that average rate, that's from the
14 hospital?

15 A. That was salary, yes.

16 Q. What about compensation that you got for
17 work outside of your hospital work?

18 A. That would vary from year to year. And the
19 range was very large. Some years it was very --
20 very little. I would say most of the years that
21 we're talking about in question here, it was
22 probably in the range of 40 or \$50,000.

23 There was -- there was a couple of years
24 that I had more consulting or more speaking, and I
25 think the highest year's compensation was a bit

1 higher than \$150,000.

2 Q. Did your income at Beth Israel, was that
3 amount decided based on -- in part at least -- on
4 income that you could bring the hospital through
5 fund-raising efforts?

6 A. I don't think so, no.

7 Q. So do you think that the hospital, to your
8 knowledge -- you were fairly high ranking -- did
9 they consider funding that they received from
10 outside sources to be important?

11 MR. ERCOLE: Objection to form.

12 BY MR. BECKWORTH:

13 Q. Based on your knowledge?

14 A. I think that the hospital certainly viewed
15 grants and other income that was brought in by a
16 department to be important to the hospital. But the
17 compensation of a chairman would just be based more
18 on fair market value for what people who chaired
19 departments get.

20 Q. Now, we've talked about getting payments to
21 the hospital and to you from each of the defendants
22 in this case, right?

23 A. Right.

24 MR. ERCOLE: Objection to form.

25

1 BY MR. BECKWORTH:

2 Q. You knew in 2007 that Purdue pled guilty to
3 a federal felony related to marketing of OxyContin?

4 A. Yes.

5 MR. ERCOLE: Objection to form.

6 BY MR. BECKWORTH:

7 Q. You knew that Purdue's CEO, medical
8 officer, and chief legal officer, all pled guilty to
9 misdemeanors, correct?

10 A. Yes.

11 Q. You still did work for Purdue after that?

12 A. Yes.

13 Q. Did you ever go to Purdue and tell it that
14 you did not want to do work for Purdue?

15 A. No.

16 Q. Did you ever go to Purdue and say that you
17 wanted to disassociate yourself from any criminal
18 activity?

19 A. No.

20 Q. You worked for at least Janssen and
21 Cephalon as we've talked about today, correct?

22 MR. ERCOLE: Objection to form.

23 THE WITNESS: I think the --

24 BY MR. BECKWORTH:

25 Q. I said that probably wrong. You did work

1 that was funded by at least Janssen and Cephalon,
2 correct?

3 A. That's correct.

4 MR. ERCOLE: Same objection.

5 BY MR. BECKWORTH:

6 Q. And you also, as we've established, were
7 involved in various third-party groups --

8 A. Yes.

9 Q. -- correct?

10 You also knew that the Robert Wood
11 Johnson Foundation provided funding to some of the
12 groups that you were involved with?

13 MR. EHSAN: Objection to form.

14 THE WITNESS: I have a vague
15 recollection that the Robert Wood Johnson Foundation
16 provided some funding to the American Pain Society,
17 but it's not a specific recollection.

18 BY MR. BECKWORTH:

19 Q. Now, based upon your personal knowledge,
20 did Janssen ever come to you and tell you that it
21 would not provide funding for anything that you were
22 involved with if you continued to be involved with
23 matters funded by Purdue?

24 A. No.

25 Q. At any point in time, to your knowledge,

1 did Janssen ever come and tell you that it would not
2 provide funding to Beth Israel if you or Beth Israel
3 received funding in any way associated with Purdue?

4 A. No.

5 Q. At any point in time, to your knowledge,
6 did Janssen ever tell the American Pain Society that
7 it would not provide funding to the American Pain
8 Society if you continued to be involved in any way
9 with Purdue?

10 MR. EHSAN: Objection to form.

11 THE WITNESS: Not to my knowledge.

12 BY MR. BECKWORTH:

13 Q. At any point in time, to your knowledge,
14 did Janssen ever tell the American Pain Foundation
15 that Janssen would not provide funding to the
16 American Pain Foundation if it continued to receive
17 funding from Purdue?

18 A. Not to my knowledge, no.

19 Q. At any point in time, did Johnson & Johnson
20 ever come to you and tell you it would not provide
21 funding to you if you continued to do work that was
22 funded in any way by Purdue?

23 A. No.

24 Q. To your knowledge, did Johnson & Johnson
25 ever come and tell that to Beth Israel?

1 A. No.

2 Q. To your knowledge, did Johnson & Johnson
3 ever come and make such a demand to the American
4 Pain Society?

5 MR. EHSAN: Object to form.

6 THE WITNESS: Not to my knowledge, no.

7 BY MR. BECKWORTH:

8 Q. To your knowledge, did Johnson & Johnson
9 ever come and make such a demand to the American
10 Pain Foundation?

11 A. Not to my knowledge, no.

12 Q. Now, you have some knowledge about what
13 opioids are --

14 A. Yes.

15 Q. -- correct?

16 And you understand that, for example,
17 OxyContin, one of the ingredients in it is something
18 called oxycodone?

19 A. Yes.

20 Q. Did Janssen ever tell you in all the times
21 that you were doing work for which it may have
22 provided funding about its involvement with Purdue
23 in the making of oxycodone?

24 A. No.

25 MR. EHSAN: Object to form.

1 BY MR. BECKWORTH:

2 Q. Did you know that Johnson & Johnson had a
3 subsidiary that grew poppies?

4 A. No.

5 Q. Did you know that Johnson & Johnson had a
6 subsidiary that made the active pharmaceutical
7 ingredient oxycodone?

8 A. No, I did not know that.

9 Q. Janssen never told you that?

10 A. No.

11 Q. Johnson & Johnson never told you that?

12 A. No.

13 MR. BECKWORTH: I'm going to hand you
14 what we'll mark as Exhibit 6.

15 (Portenoy Exhibit 6 was marked
16 for identification.)

17 BY MR. BECKWORTH:

18 Q. Sir, these are slides from a slideshow
19 produced in this case that the court has made
20 available to the public. I have two of them because
21 those are the two that are public.

22 The first one -- and take a second to
23 look at that -- you understand that opioids, at
24 least some, come from something called thebaine?

25 A. Yes.

1 Q. And thebaine comes from poppy straw?

2 A. Yes.

3 Q. Did Johnson & Johnson or Janssen ever tell
4 you about a company called Noramco?

5 A. No.

6 Q. Did they ever tell you about a company
7 called Tasmanian Alkaloids?

8 A. No.

9 Q. Did you know that Tasmanian Alkaloids grew
10 poppies from which thebaine was derived?

11 A. No.

12 Q. Let's turn to the second page of this
13 exhibit, sir.

14 Will you read for the jury what the
15 headline is.

16 MR. EHSAN: Object to form.

17 THE WITNESS: "Tasmanian Alkaloids leads
18 the world in poppy technology."

19 BY MR. BECKWORTH:

20 Q. Now, it says there next that "Patented high
21 thebaine poppy was a transformational technology
22 that enabled the growth of oxycodone."

23 Do you see that?

24 A. Yes.

25 Q. And it says that "Dr. Fist was awarded a

1 Johnson Medal."

2 Do you see that?

3 A. Yes.

4 Q. Did you know that Noramco made the active
5 pharmaceutical ingredient oxycodone and supplied it
6 to Purdue and its related entities?

7 A. No.

8 Q. Did you know that when Cephalon or Teva
9 sold a generic version of OxyContin, that they
10 actually got it from Purdue under a supply and
11 distribution agreement?

12 MR. ERCOLE: Objection to form,
13 foundation, among other things.

14 THE WITNESS: No.

15 BY MR. BECKWORTH:

16 Q. They never told you that?

17 A. No.

18 MR. ERCOLE: Objection to form.

19 BY MR. BECKWORTH:

20 Q. Did Purdue ever tell you that when their
21 pharmaceutical sales reps went into the field,
22 including in the State of Oklahoma, that they got
23 sales bonuses that were paid not only for OxyContin
24 sales, but also for the sales of generics made by
25 Cephalon?

1 MR. ERCOLE: Objection to form.

2 THE WITNESS: No, I didn't know that.

3 BY MR. BECKWORTH:

4 Q. And no one ever told you that this fellow
5 right here got the Johnson Medal for patenting the
6 high thebaine poppy that was transformational
7 technology that enabled the growth of oxycodone?

8 MR. ERCOLE: Objection to form.

9 THE WITNESS: No.

10 BY MR. BECKWORTH:

11 Q. Never told you that?

12 A. No --

13 MR. ERCOLE: Same objection.

14 THE WITNESS: -- I never was told, no.

15 BY MR. BECKWORTH:

16 Q. Is that information surprising to you?

17 MR. ERCOLE: Same objection.

18 THE WITNESS: It's new information for
19 me.

20 BY MR. BECKWORTH:

21 Q. Well, you certainly see that you were
22 involved in a lot of work funded by the drug
23 companies here today, right?

24 A. Yes.

25 MR. ERCOLE: Objection to form.

1 BY MR. BECKWORTH:

2 Q. And as we talked about earlier, a lot of
3 the things that they funded weren't specific to a
4 specific brand of drugs?

5 MR. ERCOLE: Objection to form.

6 BY MR. BECKWORTH:

7 Q. Right?

8 A. That's correct, yes.

9 Q. You understand that if you supply the
10 active pharmaceutical ingredient oxycodone that is
11 in Purdue's drug OxyContin, it would be to your
12 financial benefit if more OxyContin gets prescribed?
13 That's just common sense, isn't it?

14 MR. ERCOLE: Objection to form.

15 THE WITNESS: Yes.

16 BY MR. BECKWORTH:

17 Q. Now, the same types of questions I asked
18 you about Janssen. Did Teva or Cephalon ever come
19 to tell you that they would not provide funding to
20 anything you were doing if you continued to work for
21 Purdue?

22 MR. ERCOLE: Objection to form.

23 THE WITNESS: No.

24 BY MR. BECKWORTH:

25 Q. Did they ever come, to your knowledge, and

1 tell Beth Israel they would not provide funding for
2 work you did with Purdue?

3 THE WITNESS: No.

4 MR. ERCOLE: Objection to form.

5 BY MR. BECKWORTH:

6 Q. At any point to your knowledge, did they
7 ever tell the American Pain Society they would
8 provide no funding if you did work related to
9 Purdue?

10 MR. ERCOLE: Same objection.

11 THE WITNESS: No.

12 BY MR. BECKWORTH:

13 Q. And at no point in time to your knowledge,
14 did they ever tell the American Pain Foundation they
15 would not do any funding to the American Pain
16 Foundation if you continued to be associated with
17 Purdue?

18 A. No.

19 MR. ERCOLE: Objection to form.

20 BY MR. BECKWORTH:

21 Q. Now, you also -- as we've shown and we'll
22 look at some things today -- you did do work that
23 was funded by Cephalon from time to time, correct?

24 A. Correct.

25 Q. And do you understand that like --

1 MS. SPENCER: Are we done with P6?

2 MR. BECKWORTH: Yes, ma'am.

3 MS. SPENCER: I just want to make sure
4 where his attention is.

5 BY MR. BECKWORTH:

6 Q. You understand that Cephalon also pled
7 guilty to a federal crime, right?

8 MR. ERCOLE: Objection to form.

9 THE WITNESS: Yes.

10 BY MR. BECKWORTH:

11 Q. You understand that Cephalon pled guilty to
12 a misdemeanor, and one of the things that was
13 involved was off-label marketing of its drug Actiq?

14 MR. ERCOLE: Objection to form.

15 THE WITNESS: I don't really recall the
16 details of that case.

17 MR. BECKWORTH: Let me hand you that.

18 I will hand a copy of the plea agreement that
19 Cephalon entered into with the United States
20 Government. We'll mark this as Portenoy Exhibit 7.

21 I do not have many questions for you.
22 You can pass that along.

23 (Portenoy Exhibit 7 was marked
24 for identification.)

25 MS. SPENCER: These are previously

1 marked from another case?

2 MR. BECKWORTH: Yes. I copied -- I put
3 a sticker over that for the ease of the record.

4 MS. SPENCER: Got it.

5 BY MR. BECKWORTH:

6 Q. You see on the first page of this it says
7 "Government's memorandum for entry of plea and
8 sentencing"?

9 A. Yes.

10 Q. There's a lot in there, and I'm not going
11 to ask you specific questions to test your knowledge
12 on the plea. I just want to refer to you something
13 on page 10.

14 MS. SPENCER: There's several different
15 page 10s.

16 MR. BECKWORTH: The first page 10. Yes,
17 this is an amalgamation of related documents.

18 THE WITNESS: Okay, yes.

19 MS. SPENCER: For point of
20 clarification, it's the one that says "page 10 of
21 41" at the top?

22 MR. BECKWORTH: Yes, ma'am.

23 MS. SPENCER: Okay, thank you.

24 BY MR. BECKWORTH:

25 Q. I'm going to ask you questions about this

1 one and the next one just to refresh your memory or
2 give you some information. Here it lists "Actiq,"
3 and it says, "The case of Actiq is particularly
4 egregious, as this drug is 80 to 100 times more
5 powerful than morphine."

6 Do you see that?

7 A. Yes.

8 Q. And it talks about "The FDA-approved label
9 for Actiq"?

10 A. Yes.

11 Q. And below that, you'll read, it says,
12 "The label calls for Actiq to be prescribed by
13 oncologists or pain specialists familiar with the
14 use of opioids."

15 Do you see that?

16 A. Yes.

17 Q. If you'll turn the page. At the bottom of
18 that section, it says, "Cephalon management conveyed
19 its disregard for the FDA-approved label for Actiq
20 (opioid-tolerant cancer patients with breakthrough
21 cancer pain, to be prescribed by oncologists or pain
22 specialties familiar with opioids) to the sales
23 force."

24 Do you see that?

25 A. Yes.

1 Q. It goes on to say, "Using the mantra 'pain
2 is pain,' Cephalon instructed the sales
3 representatives to focus on physicians other than
4 oncologists, and to promote Actiq for multiple uses
5 other than breakthrough cancer pain," correct?

6 A. Yes.

7 Q. This isn't a test on what you know about
8 criminal pleas, but I just wanted to refresh your
9 memory in case you weren't aware, as you sit here
10 today.

11 Now --

12 MR. ERCOLE: Objection to form, move to
13 strike.

14 BY MR. BECKWORTH:

15 Q. -- Cephalon pled guilty to a federal
16 misdemeanor; you knew that?

17 A. Yes.

18 Q. You still did work for Cephalon after that
19 time?

20 A. Yes.

21 Q. We'll go through the same series of
22 questions here. Did you ever go to Cephalon and
23 tell it that you would not do work for it because it
24 had been involved in conduct for which it pled
25 guilty?

1 A. No.

2 MR. ERCOLE: Objection to form.

3 BY MR. BECKWORTH:

4 Q. Did Janssen ever come to you, to your
5 knowledge, and say that they would not be involved
6 with you if you remained involved with Cephalon?

7 MR. EHSAN: Objection to form.

8 THE WITNESS: No.

9 BY MR. BECKWORTH:

10 Q. Did Purdue ever come to you and tell you
11 that Purdue would not provide you funding if you
12 remained engaged in any way with Cephalon?

13 A. No.

14 Q. Did Johnson & Johnson ever come to you and
15 tell you that it would not provide you funding if
16 you remained engaged with Cephalon?

17 A. No.

18 MR. EHSAN: Object to form.

19 BY MR. BECKWORTH:

20 Q. To your knowledge, did Purdue ever go to
21 Beth Israel and tell it, As long as you are doing
22 work with Cephalon, no more funding for Beth Israel?

23 A. No.

24 Q. Did any of the drug defendants here at the
25 table do that, to your knowledge?

1 MR. ERCOLE: Objection to form.

2 THE WITNESS: Not to my knowledge, no.

3 BY MR. BECKWORTH:

4 Q. Did Purdue ever go to the American Pain
5 Society and tell it it would not provide funding, to
6 your knowledge --

7 A. No.

8 Q. -- if work was still -- or funding was
9 still accepted by Cephalon?

10 A. Not to my knowledge, no.

11 Q. Did they ever do that to the American Pain
12 Foundation?

13 A. Not to my knowledge.

14 Q. What about Janssen & Janssen [sic]?

15 MR. ERCOLE: Objection to the form.

16 THE WITNESS: Not to my knowledge.

17 BY MR. BECKWORTH:

18 Q. What about Teva?

19 MR. ERCOLE: Objection to form.

20 THE WITNESS: Not to my knowledge, no.

21 BY MR. BECKWORTH:

22 Q. And what about -- make sure I got this --
23 how about this -- what about any Janssen & Janssen
24 [sic] or Johnson & Johnson company?

25 MR. EHSAN: Objection to form.

1 THE WITNESS: Not to my knowledge, no.

2 BY MR. BECKWORTH:

3 Q. Did Teva, to your knowledge?

4 MR. ERCOLE: Objection to form.

5 THE WITNESS: Not to my knowledge.

6 BY MR. BECKWORTH:

7 Q. In fact, you are aware that at some point
8 after this, Teva actually acquired Cephalon?

9 A. Yes.

10 MR. ERCOLE: Objection to form.

11 BY MR. BECKWORTH:

12 Q. Now, you also did work for Insys, correct?

13 A. I know that there was an agreement, but I
14 don't remember the specific work.

15 Q. And I'm not in any way insinuating you did
16 work. What I'm about to show you -- I'm just going
17 to ask you a few questions about this -- you
18 understand that recently Insys's CEO pled guilty to
19 a federal crime related to its opioids, right?

20 A. I was aware of the investigation. I didn't
21 actually know that there was a guilty plea.

22 (Portenoy Exhibit 8 was marked
23 for identification.)

24 BY MR. BECKWORTH:

25 Q. I'll hand you a very short article on this.

1 If you'll pass it around to your attorney.

2 MS. SPENCER: And this is P8?

3 MR. BECKWORTH: Yes.

4 BY MR. BECKWORTH:

5 Q. Now, in this article that's Exhibit 8, it
6 shows that the CEO of Insys has pled guilty to a
7 federal crime for paying kickbacks to prescribers
8 for prescribing Insys's -- I don't know how you
9 pronounce that -- Insys's sublingual opioid, correct?

10 A. That's correct, yes.

11 Q. Now, we're done with that.

12 That's a pretty serious matter?

13 A. Yes, absolutely.

14 Q. Having a doctor get paid a kickback?

15 A. Um-hum.

16 Q. Yes?

17 A. Yes, very serious.

18 Q. Now, same questions. At any point in time,
19 to your knowledge, did any of the defendants in this
20 case tell you that they would not do work -- or
21 provide funding for any work that you did if you
22 worked in any way with Insys?

23 MR. ERCOLE: Objection to form.

24 THE WITNESS: No.

25

1 BY MR. BECKWORTH:

2 Q. Same for Beth Israel?

3 MR. ERCOLE: Objection to form.

4 THE WITNESS: To my knowledge, no, they
5 did not.

6 BY MR. BECKWORTH:

7 Q. And to your knowledge, they never went to
8 the APS or APF and said, No funding if you do work
9 that involves Insys?

10 MR. ERCOLE: Objection to form.

11 THE WITNESS: To my knowledge, that
12 didn't happen.

13 BY MR. BECKWORTH:

14 Q. Now, you're also familiar that Endo made a
15 drug called Opana?

16 A. Yes.

17 Q. And that's an opioid?

18 A. Yes.

19 MR. BECKWORTH: I'm going to hand you
20 Exhibit 10 -- sorry. I'll hand you Exhibit 9.

21 (Portenoy Exhibit 9 was marked
22 for identification.)

23 MS. SPENCER: I need another one for
24 defendants -- or is there another one there?

25 THE WITNESS: No.

1 MS. SPENCER: I'll share with the
2 witness.

3 MR. BECKWORTH: I don't mind you seeing
4 my highlighted copy.

5 MS. SPENCER: No, no. I'll just share
6 with the witness.

7 BY MR. BECKWORTH:

8 Q. Now, sir, Exhibit 9 is a June 8, 2007 [sic]
9 FDA news release?

10 A. Yes.

11 Q. And you're aware that the FDA requested
12 Opana ER to be removed from the shelf, correct?

13 A. Yes, I was aware of that.

14 Q. That's a serious matter?

15 A. I didn't actually take the time to get the
16 details of this, so I'm not sure why this was
17 removed. Can I take a moment to read this?

18 Q. You bet.

19 MS. SPENCER: And I would request if we
20 at some point during the break maybe make another
21 copy so I can have a copy for my records.

22 MR. BECKWORTH: Sure.

23 THE WITNESS: I see, yes.

24 BY MR. BECKWORTH:

25 Q. So here we see that the FDA determined that

1 the risk of abuse of this drug outweighed the
2 benefits?

3 A. Yes.

4 Q. And asked that it be removed from the
5 shelves?

6 MR. ERCOLE: Objection to form.

7 THE WITNESS: That's correct.

8 BY MR. BECKWORTH:

9 Q. And in this document, there's a statement
10 from a commissioner of the FDA named Scott Gottlieb?

11 A. Yes.

12 Q. A medical doctor?

13 A. Yes.

14 Q. And it says, "We are facing an opioid
15 epidemic -- a public health crisis, and we must take
16 all necessary steps to reduce the scope of opioid
17 misuse and abuse," correct?

18 A. Yes.

19 Q. So we've shown -- or you've shown in your
20 declaration, sir, that Endo was one of the companies
21 that provided funding for various work, correct?

22 A. Yes.

23 Q. And at any point in time, did any of the
24 drug companies here tell you that they would not
25 support anything you were doing if you were also

1 receiving money from Endo?

2 A. No.

3 MR. ERCOLE: Objection to form.

4 THE WITNESS: No, they did not.

5 BY MR. BECKWORTH:

6 Q. And they never said that to Beth Israel, to
7 your knowledge either?

8 MR. ERCOLE: Objection to form.

9 THE WITNESS: Not to my knowledge, no.

10 BY MR. BECKWORTH:

11 Q. Now, continuing on in your list here --

12 MS. SPENCER: We're back to the
13 declaration?

14 MR. BECKWORTH: Yes, ma'am, paragraph 30.

15 BY MR. BECKWORTH:

16 Q. Just a couple of others. You list that
17 on -- at some point, there was a program in 2010,
18 January 19, when you chaired a meeting to develop a
19 curriculum for a CME program called "Balancing
20 chronic pain management and rational opioid use for
21 primary care providers"?

22 A. Yes.

23 Q. And to your knowledge, that program was
24 sponsored by Janssen and Endo?

25 A. Yes.

1 Q. And that's after the Purdue guilty plea and
2 after the Cephalon plea, correct?

3 MR. ERCOLE: Objection to form.

4 THE WITNESS: Yes.

5 BY MR. BECKWORTH:

6 Q. Now, on August 28, 2010, you list that you
7 participated in a physician advisory board meeting
8 for Purdue, correct?

9 A. Yes.

10 Q. And then in May 2010, you moderated an
11 online program called "Medico-legal issues, clinical
12 guidelines and opioid dose conversions" for the
13 website emergingsolutionsinpain.com?

14 A. Yes.

15 Q. You understand that online program was
16 supported by Cephalon, Endo, and Purdue?

17 A. I believe so, yes.

18 Q. And you were paid \$2,000 for that?

19 A. Yes.

20 Q. On February 11, 2011, you entered into an
21 advisory board agreement with Cephalon, correct?

22 A. Yes.

23 Q. You were paid for that?

24 A. I presume so.

25 MR. ERCOLE: Objection to form.

1 BY MR. BECKWORTH:

2 Q. And you also list that on February 5, 2010,
3 you entered into a consulting agreement with
4 Mallinckrodt to advise on pain and addiction
5 medicine?

6 A. Yes.

7 Q. You were paid \$3,500 for that?

8 A. Yes.

9 Q. And then on November 15, 2010, you entered
10 into an educational preceptorship agreement with
11 Mallinckrodt for the purpose of educating
12 Mallinckrodt's medical science liaison on clinical
13 practice?

14 A. Yes.

15 Q. You were paid \$8,000 for that?

16 A. Yes.

17 Q. Now, in addition to all this work as we've
18 discussed, you were on the Janssen Speakers Bureau,
19 correct?

20 A. I don't recall that. It's possible. I'd
21 have to be reminded of the years that that was the
22 case.

23 MR. BECKWORTH: I'm going to hand you
24 what we'll label as Exhibit 10.

25

1 (Portenoy Exhibit 10 was marked
2 for identification.)

3 BY MR. BECKWORTH:

4 Q. Just for the record, while you're looking
5 at this, Exhibit 10 is a Janssen document.

6 MS. SPENCER: It's very small.

7 BY MR. BECKWORTH:

8 Q. It is very small. It says "Speaker
9 analysis summary - Duragesic 11/11/2002."

10 You're mentioned in here. I'm going to
11 help you get to there. If you'll turn to -- when
12 you get a second, familiarize yourself with this,
13 and turn to the fifth page, please, sir, and you're
14 close to the bottom. The third column from the left
15 is in alphabetical order.

16 A. I'm sorry. You said on the third page?

17 Q. No. I think I said the fifth.

18 A. Fifth page. Um-hum.

19 Q. Do you see your name, sir?

20 A. Yes.

21 Q. Now, it lists, "Dr. Russell Portenoy, M.D.,
22 pain management, New York, New York"?

23 A. Um-hum.

24 Q. And it gives a phone number, correct?

25 A. Yes.

1 Q. If you look over there to the next, we see
2 a number 3?

3 A. Yes.

4 Q. And I'll represent to you from looking at
5 the first page, that's under the column "Total
6 number 2001 lectures"?

7 A. Um-hum, yes.

8 Q. And if you look at the next one, you see
9 a 1?

10 A. Um-hum.

11 Q. And if you look at the first page, that
12 refers to "Total number 2002 lectures."

13 Do you see that?

14 A. Yes.

15 Q. And then the next one lists a number 4.
16 And it says "Total number of lectures," correct?

17 A. Yes.

18 Q. And then beside that, it has "National
19 honorarium," and it has \$1,500.

20 Do you see that?

21 A. Yes.

22 Q. So this shows that you were on a speaker
23 list for Duragesic at least in this time period,
24 correct?

25 MR. EHSAN: Object to form.

1 THE WITNESS: Right. It doesn't show,
2 however, that I was on a speakers bureau. I don't
3 have a specific recollection of joining that
4 speakers bureau, which is what I said before. But I
5 certainly gave talks during this time frame, which
6 is what's indicated here.

7 BY MR. BECKWORTH:

8 Q. That's fine. And that's a term -- people
9 use "speakers bureaus," "speakers lists." So I want
10 to make sure we're accurate.

11 A. Right.

12 Q. So you're listed here as a paid speaker
13 during this time period related to Duragesic,
14 correct?

15 A. Yes.

16 MR. BECKWORTH: Now, I'm going to hand
17 you a document provided by Johnson & Johnson. We'll
18 label this as Exhibit 11.

19 MS. SPENCER: One moment. The witness
20 is examining the document.

21 THE WITNESS: That's fine.

22 MS. SPENCER: Are you okay.

23 MR. BECKWORTH: Take your time. Is
24 there anything you need to say about it?

25 THE WITNESS: No.

1 (Portenoy Exhibit 11 was marked
2 for identification.)

3 BY MR. BECKWORTH:

4 Q. I didn't print these, or I promise you the
5 print would not be so small. This is a document
6 provided by Johnson & Johnson -- we're just going to
7 look at the first page -- that lists payments made
8 to various entities "in response to the Senate
9 Finance Committee request dated May 8, 2012."

10 Do you see that?

11 A. Yes.

12 Q. And I'm just going to focus on ones that I
13 believe you -- I'm going to try to focus on entities
14 that you may have been involved with. The first one
15 listed is the American Pain Foundation. And if
16 you'll look over to the right, it shows payments
17 from 1997 to 2012 totaling \$633,300, correct?

18 A. Yes.

19 Q. Now, the next one is the American Academy
20 of Pain Medicine. You're familiar with that, right?

21 A. Yes.

22 Q. You weren't on the board though?

23 A. No.

24 Q. But to the right here it shows during that
25 time period payments of \$562,674?

1 A. Yes.

2 Q. And then the next one is the American Pain
3 Society, correct?

4 A. Yes.

5 Q. And during that same time period, it shows
6 payments of \$1,793,906, correct?

7 A. Yes.

8 Q. And then later on it says "Russell K.
9 Portenoy, M.D."

10 Do you see that?

11 A. Yes.

12 Q. And during that same time period, it shows
13 \$28,940, correct?

14 A. Yes.

15 Q. Now, do you see the Beth Israel Medical
16 Center?

17 A. Yes.

18 Q. That shows a zero -- I'm sorry -- during
19 that time period, correct?

20 A. Yes.

21 Q. Now, as we talked about earlier, you
22 understand that the Senate Finance inquiry had a
23 negative impact on the American Pain Foundation,
24 correct?

25 A. Yes.

1 Q. It was no longer able to survive after it
2 stopped taking money from drug companies?

3 MR. ERCOLE: Objection to form.

4 THE WITNESS: Yes.

5 BY MR. BECKWORTH:

6 Q. Now, we know that from time to time,
7 Johnson & Johnson would pay Beth Israel money for
8 work related to you, correct?

9 MR. EHSAN: Object to form.

10 THE WITNESS: Yeah. I'd have to have
11 more specifics about that question.

12 MR. BECKWORTH: Well, let's just show
13 you an example. How about that?

14 THE WITNESS: That would be fine.

15 MR. BECKWORTH: I'm going to hand you an
16 invoice.

17 (Portenoy Exhibit 12 was marked
18 for identification.)

19 MS. SPENCER: This is P12?

20 MR. BECKWORTH: Yes, ma'am.

21 BY MR. BECKWORTH:

22 Q. Sir, Exhibit 12 is an invoice produced by
23 Janssen showing payment made by Ortho-McNeil-Janssen
24 Scientific Affairs to Beth Israel Medical Center,
25 correct?

1 A. Yes.

2 Q. And it's for services provided by you?

3 A. I would say it's for services provided by
4 me and my departmental colleagues in creating this
5 material.

6 Q. And it says, "Description . . . provided:
7 Emerging practices in opioid prescribing for chronic
8 pain - enduring materials on QuantiaMD"?

9 A. Yes.

10 Q. "Completion and posting of six lectures,"
11 correct?

12 A. Yes.

13 Q. And it shows here a payment of \$40,000?

14 A. Yes.

15 Q. So this is one of those examples we talked
16 about where the drug company provides funding to the
17 hospital, but it's related to worker services that
18 you and others were actually doing?

19 A. Yes.

20 MR. BECKWORTH: Now, I'll give you a
21 couple more of these. This work was paid in
22 multiple invoices. I'll hand you what we'll mark as
23 Exhibit 13.

24 (Portenoy Exhibit 13 was marked
25 for identification.)

1 BY MR. BECKWORTH:

2 Q. While you look at that, I'll represent to
3 you that Exhibit 13 is another invoice related to
4 this same scope of work. And there, the sum of
5 \$20,000 was paid, correct?

6 A. Yes.

7 MR. BECKWORTH: Now I'll hand you
8 Exhibit 14.

9 (Portenoy Exhibit 14 was marked
10 for identification.)

11 BY MR. BECKWORTH:

12 Q. You might keep the one you're looking at
13 handy on this one. Hand you Exhibit 14, sir.

14 A. I think this is the same as the last one.

15 Q. Well, it appears that way at first, but
16 when you look at the invoice numbers, do you see
17 that they're two different ones?

18 A. Yeah.

19 Q. So Exhibit 13 and Exhibit 14 have different
20 invoice numbers, correct?

21 A. Right.

22 Q. But it shows on Exhibit 14 a payment of
23 \$20,000, right?

24 A. Yes.

25 Q. Okay. We're done with those. Thank you.

1 Now, you also did some work --

2 MS. SPENCER: We've been -- just for
3 the -- we've been going for a couple of hours now.

4 (To the witness:) Do you need a break
5 or are you good?

6 THE WITNESS: I'm fine.

7 MR. BECKWORTH: If I could maybe have
8 five-ish, I can get through this section and we can
9 move on.

10 MS. SPENCER: Sure. I just didn't know
11 if this was a stopping point or not.

12 MR. BECKWORTH: And if this nice lady to
13 my left tells us to stop, we're going to stop.

14 I'm going to hand you what we'll mark as
15 Exhibit 15.

16 (Portenoy Exhibit 15 was marked
17 for identification.)

18 BY MR. BECKWORTH:

19 Q. You referenced some work for Cephalon.
20 I'll hand you Exhibit 15, sir.

21 A. Yes.

22 MR. EHSAN: Is this 14?

23 MR. ERCOLE: 15.

24 MS. SPENCER: This is a lengthy
25 document.

1 MR. BECKWORTH: Yes.

2 MS. SPENCER: The witness can take a
3 minute and familiarize himself with it.

4 MR. BECKWORTH: He can, and just to help
5 with that --

6 You can look at all you want. I'm going
7 to ask you about the type of program that's at issue
8 here, and there's a grant amount on the third page,
9 paragraph 5, it's numbered 5. If you need to look
10 at more, please do so.

11 MS. SPENCER: I need a minute to look at
12 the document also.

13 MR. BECKWORTH: Take your time.

14 MS. SPENCER: Thank you.

15 BY MR. BECKWORTH:

16 Q. As you look through here, you'll see this
17 is the culmination of some emails and requests for a
18 grant for presentation of this exhibit.

19 A. Correct.

20 MR. ERCOLE: Objection to form.

21 MS. SPENCER: I need just a few more
22 moments.

23 All right. I think we're good. If I
24 need any more time, I'll let you know.

25 MR. BECKWORTH: Just let me know.

1 BY MR. BECKWORTH:

2 Q. Sir, so if you look through this, this
3 document started after the pages we asked you to
4 look at. But there was an effort to get funding for
5 a CME that would be happening, correct?

6 A. Yes.

7 Q. And ultimately Cephalon agreed to provide
8 some funding --

9 A. Yes.

10 Q. -- correct?

11 And on this Exhibit 15, we'll see that
12 on October 26, 2007, there was an agreement entered
13 into to provide funding through a grant to Beth
14 Israel Medical Center, correct?

15 A. Yes.

16 MS. SPENCER: What page are you on?

17 MR. BECKWORTH: Second page of the
18 document. It ends with 3803.

19 MS. SPENCER: Thank you.

20 BY MR. BECKWORTH:

21 Q. And you'll see on the bottom left -- well,
22 where it says "Type of program," it's got the box
23 checked for "Accredited (continuing medical
24 education or 'CME')," correct?

25 A. Yes.

1 Q. And on "Purpose of educational program," it
2 says, "The educational program is for scientific and
3 educational purposes only and is not intended to
4 promote a Cephalon product, directly or indirectly.
5 The program is not a repeat performance of a prior
6 program," correct?

7 A. Correct.

8 Q. Then we have a paragraph titled
9 "Independence." And then let's turn to the next
10 page. It shows the amount of the grant here, which
11 is \$25,000, correct?

12 A. Yes.

13 Q. And then it goes on to talk about use of
14 this money, disclosure, and other things, correct?

15 A. Yes.

16 Q. That's all I have of that. Now, sir, you
17 are -- as we've discussed, you were involved with
18 American Pain Society?

19 A. Yes.

20 Q. The American Pain Society had you prepare a
21 disclosure of monies you'd received from the
22 pharmaceutical industry as part of a conflict of
23 interest policy; is that correct?

24 A. I imagine so, yeah.

25 MR. BECKWORTH: I'm going to hand you a

1 document that involves that, Exhibit 16.

2 (Portenoy Exhibit 16 was marked
3 for identification.)

4 BY MR. BECKWORTH:

5 Q. Exhibit 16 is titled "Conflict of interest
6 disclosure form" for the American Pain Society; do
7 you see that?

8 A. Yes.

9 Q. I'm going to walk you through some of it
10 real quickly. Take your time if you need to look at
11 more. There's a section labeled "Research funding"?

12 MS. SPENCER: Where are you?

13 MR. BECKWORTH: It says "page 4 of 7."

14 MS. SPENCER: Um-hum.

15 BY MR. BECKWORTH:

16 Q. And under "Research funding," it lists
17 grants of \$10,000 or less between 2003 and 2006 for
18 the DPMPC chaired by you, correct?

19 A. Yes.

20 Q. There are quite a few entities listed here?

21 A. Yes.

22 Q. We see Endo Pharmaceuticals is one?

23 A. Yes.

24 Q. Meeting Concepts, LLC is one?

25 A. Yes.

1 Q. Purdue Pharma, L.P. is one?

2 A. Yes.

3 Q. Now, if we turn to the next page, please,
4 sir.

5 A. Um-hum.

6 Q. It lists grants to the DPMPC in the \$10,001
7 to \$100,000 range?

8 A. Yes.

9 Q. And among others, we see Cephalon?

10 A. Yes.

11 Q. We see Endo?

12 A. Yes.

13 Q. We see Janssen Medical Affairs, LLC?

14 A. Yes.

15 Q. We see Purdue?

16 A. Yes.

17 Q. Now, if you look to the next part, it lists
18 in that same time period grants to the DPMPC of
19 \$100,000 or more, and we see -- among others, we see
20 one from Janssen Medical Affairs, LLC, correct?

21 A. Yes.

22 Q. Now, if we go to the next page, it also
23 lists grants for sponsored clinical trials from
24 several companies?

25 A. Yes.

1 Q. And included there are Cephalon, Inc.?

2 A. Yes.

3 Q. Endo Pharmaceuticals, Inc.?

4 A. Yes.

5 Q. Purdue Pharma, L.P.?

6 A. Yes.

7 Q. And others?

8 A. Yes.

9 Q. And then finally, there's an addendum that
10 says during this same time period of 2003 to 2006,
11 you received compensation as a consultant from
12 several companies, correct?

13 A. Yes.

14 Q. And in there we see Cephalon?

15 A. Yes.

16 Q. Endo?

17 A. Yes.

18 Q. And Janssen Pharmaceuticals?

19 A. Yes.

20 Q. Among others?

21 A. Yes.

22 Q. Thank you. I've just got a few more and
23 we'll take a break.

24 Now, we talked earlier about how some of
25 this funding actually occurs. I'm going to hand you

1 a document we'll mark as Exhibit 17, sir. This is a
2 document produced by Purdue.

3 (Portenoy Exhibit 17 was marked
4 for identification.)

5 BY MR. BECKWORTH:

6 Q. If you want to take a second to look at
7 that.

8 Now, Exhibit --

9 MS. SPENCER: Just hold on.

10 MR. BECKWORTH: You bet.

11 MS. SPENCER: Okay. If the witness is
12 ready.

13 THE WITNESS: Yes.

14 BY MR. BECKWORTH:

15 Q. Exhibit 17 is a letter dated February 27,
16 1997, correct?

17 A. Yes.

18 Q. It's from you?

19 A. Yes.

20 Q. And it's to a gentleman, the director of
21 CME at the Reading Hospital in Pennsylvania,
22 correct?

23 A. Yes.

24 Q. And in it, it is you responding to an
25 invitation to speak at the hospital, correct?

1 A. Yes.

2 Q. And in there, you say that your honorarium
3 for a two-day visit will be \$2,500 plus travel
4 expenses, correct?

5 A. Yes.

6 Q. And you say there, "I am a member of the
7 Purdue Frederick, Roxane and Janssen Speakers
8 Bureaus."

9 Do you see that?

10 A. Yes.

11 Q. Now, we talked about speakers bureaus
12 earlier and I said we all kind of say it
13 differently. At least in this document, you see
14 that it's showing that you are a member of the
15 Janssen Speakers Bureau?

16 A. Right.

17 Q. And also the Purdue Frederick Speakers
18 Bureau?

19 A. Right.

20 Q. And it says from you that perhaps this
21 gentleman could solicit funding from one of these
22 companies to provide your honorarium, correct?

23 A. That's correct, right.

24 Q. And we talked about earlier that's how
25 things were done at that time, correct?

1 A. Correct.

2 MR. ERCOLE: Objection to form.

3 MR. EHSAN: Objection to form.

4 MR. BECKWORTH: Now, I'm going to hand
5 you what we'll mark as Exhibit 18. I don't have a
6 copy so I'll just give it to you.

7 (Portenoy Exhibit 18 was marked
8 for identification.)

9 MS. SPENCER: This is 18?

10 MR. BECKWORTH: Yes, ma'am.

11 BY MR. BECKWORTH:

12 Q. Have you had a chance to look at that, sir?

13 A. Yes.

14 Q. And in this, you'll see where the payment
15 was actually made, correct?

16 A. Yes.

17 Q. And here we have the \$2,500 honoraria
18 actually being paid by Purdue Frederick?

19 A. Yes.

20 Q. To the entity that you had reached out --
21 that had reached out to you --

22 A. Yes.

23 Q. -- correct?

24 And it says to you to make sure that
25 your travel expenses are actually sent to that

1 hospital, not Purdue Frederick, correct?

2 A. Yes.

3 MR. BECKWORTH: Thank you. We'll do two
4 more real quick, and we'll take a break --

5 MS. SPENCER: Sure.

6 MR. BECKWORTH: -- if that's okay with
7 everybody.

8 BY MR. BECKWORTH:

9 Q. You're familiar that the United States
10 Senate Committee looked into funding to various
11 entities by pharmaceutical companies, correct?

12 A. Yes.

13 MR. ERCOLE: Objection to form.

14 MR. BECKWORTH: I'm going to hand you a
15 copy of that minority staff report titled "Fueling
16 an epidemic." It's Exhibit 19.

17 (Portenoy Exhibit 19 was marked
18 for identification.)

19 BY MR. BECKWORTH:

20 Q. I'm just going to ask you a few questions.

21 MS. SPENCER: I'm going to need a minute
22 to take a look at this.

23 MR. BECKWORTH: You bet. For your
24 reference, I'm going to focus on page 4.

25 MS. SPENCER: Okay.

1 MR. BECKWORTH: And page 6.

2 BY MR. BECKWORTH:

3 Q. Sir, if we can turn to page 4 --

4 MS. SPENCER: I need more time. I'm
5 sorry. I'll allow him to answer questions about
6 this obviously. But you're going to ask him
7 specific questions, you're not asking him to adopt
8 any views outside of the questions that you ask him
9 in this document?

10 MR. BECKWORTH: Not at all. You're
11 correct.

12 BY MR. BECKWORTH:

13 Q. So, sir, on page 4 --

14 MS. SPENCER: If he's ready, we can
15 proceed.

16 THE WITNESS: I'm ready. Thank you.

17 BY MR. BECKWORTH:

18 Q. -- you'll see that there's a grid there
19 that lists reported manufacture payments to selected
20 groups between 2012 and 2017.

21 Do you see that?

22 A. Yes.

23 Q. And it lists Purdue, Janssen, Depomed,
24 Insys -- and I don't know if that's Mylan or Milan.

25 Do you see those?

1 A. Yes.

2 Q. With respect to the American Academy of
3 Pain Medicine, it shows \$725,584.95 from Purdue?

4 A. Yes.

5 Q. And -- correct?

6 A. Correct, yes.

7 Q. And \$83,975 by Janssen --

8 A. Correct.

9 Q. -- during that time period. Correct?

10 A. Yes.

11 Q. And then we also have the American Pain
12 Society, it lists \$542,259.52 from Purdue --

13 A. Yes.

14 Q. -- correct?

15 A. That's correct.

16 Q. And \$88,500 from Janssen?

17 A. That's correct.

18 Q. And it's limited to that time period,
19 correct?

20 A. Yes. That's correct.

21 MR. BECKWORTH: Thank you. Now, last
22 one and then we'll take a short break. I'm going to
23 hand you Exhibit 20.

24 I'll note, Mrs. Spencer, I have no other
25 questions other than it is what it is, and if you'll

1 let me ask my question, you may have an easier way
2 to do this.

3 (Portenoy Exhibit 20 was marked
4 for identification.)

5 BY MR. BECKWORTH:

6 Q. We served you with a subpoena for records
7 in this case. Are you aware of that?

8 A. Yes.

9 Q. And through your attorney, records were
10 provided to us, correct?

11 A. Correct.

12 Q. And included in that were 1099s and
13 payments that you had in your possession that showed
14 amounts you'd been paid from various entities,
15 correct?

16 A. That's correct.

17 Q. And I'll represent to you that what I've
18 handed to you in Exhibit 20 bears a Bates stamp
19 showing documents provided from you, Dr. Portenoy.

20 Do you see that on the bottom right-hand
21 side?

22 A. Yes.

23 Q. And all I want to ask you is if that's a
24 true and correct copy of the documents you provided
25 us?

1 A. To the best of my knowledge, yes.

2 Q. And those are business records that you
3 provided that show various payments and related
4 memorialization of that from various sources,
5 correct?

6 A. Correct.

7 Q. And there's a confidentiality order in its
8 place and I'm sure that -- I know that you've
9 already signed it, so just so you understand your
10 personal information is not going to be sent out to
11 the public.

12 A. Thank you.

13 MS. SPENCER: And on that point, I
14 apologize, I forgot to say this at the beginning.
15 This proceeding is subject to that confidentiality
16 agreement and the protective order, correct?

17 MR. BECKWORTH: He signed it, yes.

18 MS. SPENCER: No, no. This proceeding.
19 Nothing that is said or goes on here in this
20 proceeding is subject to public disclosure outside
21 of the confines of the -- like, this is marked
22 confidential, this proceeding?

23 MR. BECKWORTH: Yes. There's a
24 procedure for doing that for depositions under the
25 protective order.

1 MS. SPENCER: Right.

2 MR. BECKWORTH: We'll make sure you have
3 that.

4 MS. SPENCER: Okay, great.

5 MR. BECKWORTH: So that you do what you
6 need to do if you want to.

7 MS. SPENCER: Great. Thank you.

8 MR. BECKWORTH: Do y'all want to take a
9 break?

10 MS. SPENCER: Yes.

11 MR. BECKWORTH: I wouldn't mind it.

12 THE VIDEO OPERATOR: Off the record,
13 1:03.

14 (Whereupon, at 1:03 p.m.,
15 the deposition was recessed,
16 to reconvene at 1:45 p.m.
17 this same date.)

18

19

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1 AFTERNOON SESSION

2 (2:20 p.m.)

3 THE VIDEO OPERATOR: Back on the record,
4 2:20.

5 MR. ERCOLE: As we move forward, can I
6 ask, Mr. Beckworth, is this being streamed? And if
7 so, to whom?

8 MR. BECKWORTH: It's being streamed to
9 my colleagues.

10 MR. ERCOLE: Who are your colleagues?

11 MR. BECKWORTH: My lawyers.

12 MR. ERCOLE: So it is being streamed?

13 MR. BECKWORTH: To my legal team, yes.

14 MR. ERCOLE: Thank you for now letting
15 us know that.

16 MR. BECKWORTH: Are we going on the
17 record? All that doesn't count against my time, by
18 the way. Are we ready to proceed?

19 MS. SPENCER: Go ahead.

20 MR. BECKWORTH: Thank you.

21 RUSSELL PORTENOY, M.D.,
22 the witness at the time of recess, having
23 been previously duly sworn, was further
24 deposed and testified as follows:
25

1 EXAMINATION (continued)

2 BY MR. BECKWORTH:

3 Q. Dr. Portenoy, you know that during your
4 career you've written many papers regarding the
5 treatment of pain, cancer, noncancer, and
6 palliative, correct?

7 A. Yes.

8 MR. ERCOLE: I'm going to renew my
9 objection to the leading questions that the State
10 has asked throughout the entirety of this deposition
11 and just get a standing objection.

12 MR. BECKWORTH: You don't get a standing
13 objection.

14 BY MR. BECKWORTH:

15 Q. Now, Dr. Portenoy, you understand that what
16 he's trying to say is that you're a witness that I
17 control. I don't control you, right?

18 A. No.

19 MR. ERCOLE: Objection, form, leading.

20 BY MR. BECKWORTH:

21 Q. In fact, the State of Oklahoma doesn't
22 represent you?

23 A. That's correct.

24 Q. You're not trying to do intentionally
25 anything favorable or unfavorable to our case,

1 right?

2 MR. ERCOLE: Objection to form.

3 THE WITNESS: Right.

4 BY MR. BECKWORTH:

5 Q. You're here represented by your own
6 attorney?

7 A. Right.

8 Q. She represents you?

9 A. Yes.

10 Q. And you have the ability to answer
11 questions truthfully? That's your choice, correct?

12 A. Yes.

13 MR. ERCOLE: Objection to form.

14 BY MR. BECKWORTH:

15 Q. And you don't have a business relationship
16 with the State of Oklahoma?

17 A. No.

18 Q. You have no formal settlement agreement
19 with the State of Oklahoma?

20 A. No.

21 Q. You testify truthfully and that's your
22 choice to do so or not to do so, correct?

23 A. Correct.

24 Q. Thank you. Now, you wrote papers
25 throughout your career?

1 A. Yes.

2 Q. And those papers included the treatment of
3 pain?

4 A. Yes.

5 Q. Palliative, cancer, noncancer?

6 A. Yes.

7 MR. ERCOLE: I'll renew my standing
8 objection to the leading question.

9 MR. BECKWORTH: You do not have a
10 standing objection.

11 BY MR. BECKWORTH:

12 Q. The treatment of pain through opioids was
13 something that prior to 1995 there were a lot of
14 fears about doing that for the chronic noncancer
15 pain area; would you agree?

16 MR. ERCOLE: Objection to form.

17 THE WITNESS: I think the fears
18 continued after 1995. There have been historically
19 always fears about using opioids.

20 BY MR. BECKWORTH:

21 Q. Opioids had been used prior to 1995 for
22 palliative care?

23 A. Yes.

24 Q. In the acute setting, surgeries, things
25 like that?

1 A. Yes.

2 Q. But broad use of opioids in the chronic
3 pain areas like low back pain and some of the things
4 we discussed earlier, that was not broadly done
5 prior to 1995; do you agree?

6 A. That's correct, yes.

7 MR. ERCOLE: Objection to form.

8 BY MR. BECKWORTH:

9 Q. And there were concerns about some of the
10 negative consequences that can occur with these
11 drugs like tolerance?

12 A. Yes.

13 Q. Addiction?

14 A. Yes.

15 Q. Physical dependence?

16 A. Yes.

17 Q. The risk for abuse?

18 A. Yes.

19 Q. And misuse?

20 A. Yes.

21 Q. Diversion?

22 A. Yes.

23 Q. And the problem of potential addiction?

24 A. Yes.

25 Q. Based upon your experience, it is your

1 belief that when the drug company defendants used
2 your work, that there were times they did not fully
3 cite to the warnings and qualifications you gave
4 about these and other risks associated with these
5 use of opioids in the chronic pain space, correct?

6 MR. ERCOLE: Objection to form.

7 THE WITNESS: Yes. From the very first
8 paper that I wrote about opioids in 1986, I was
9 always trying to speak about their use with respect
10 to both the potential benefit that I believe they
11 had and can still have today, if they're used
12 appropriately, and also about their risk.

13 The very first guideline -- the very
14 first item in the very first guideline that we
15 published in 1986 said that opioids should only be
16 considered after all other reasonable approaches for
17 pain control have not worked.

18 And it's my view, I've come to conclude
19 that the opioid manufacturers essentially distilled
20 out the positive messages and failed to mention or
21 failed to emphasize appropriately the risks and the
22 context that was included in papers like the very
23 first one that I wrote.

24 And that's what I mean when I made that
25 statement in the declaration: that the materials

1 that I wrote included information that I thought
2 could help destigmatize these drugs, give doctors
3 real information about their actual pharmacology,
4 about the data that was out there, disabuse them of
5 some of the excessive concerns that they had that
6 were not really based on science.

7 But at the same time I always framed
8 that in the context that said, but these drugs could
9 be abused, but these drugs could lead to addiction,
10 and that's why they shouldn't be first used, and
11 that's why they should only be used in carefully
12 selected patients, and that's why they should be
13 monitored in a specific way.

14 And I think that that context and those
15 messages about risk were neglected, de-emphasized,
16 and the pharmaceutical industry, for understandable
17 reasons, would take the positives, distill out the
18 positives for their messaging.

19 BY MR. BECKWORTH:

20 Q. What do you believe -- or what do you mean
21 by, for understandable reasons, they took only the
22 positive?

23 A. I think the -- I think that the purpose of
24 doing that was to improve the sales of their drug.
25 And in order -- and obviously to the extent that

1 physicians were given a sense of assurance that the
2 risks were not significant, the drug would do better
3 in the marketplace.

4 So that there was that overarching
5 consideration, I think, in the way that the
6 pharmaceutical industry decided to market its
7 products, to speak about the benefits that people
8 like myself were writing about without providing the
9 context related to risk and the caution in selecting
10 the right patient, because the message was more
11 likely to lead to marketing advantage if they did
12 not include the negatives.

13 Q. And would using the work of you or any
14 academic or doctor in a way that doesn't show both
15 the positive and negative consequences of using
16 these drugs in this way, would that be misleading?

17 MR. ERCOLE: Objection to form.

18 THE WITNESS: It can be misleading.
19 And I'll just say that initially we did not see a
20 public health crisis occurring. In other words, the
21 public health problem of opioids producing an
22 increasing rate of unintended overdose and death,
23 increasing rates of abuse, and increasing rates of
24 addiction, that all occurred after some years of
25 this new way of thinking about opioids was being

1 discussed by the academic community.

2 I think that the drug companies were
3 slow to recalibrate, to change their messages to try
4 to incorporate more about risk as it became clearer
5 that the public health implications of greater
6 opioid use warranted more focus on risk.

7 And in that way, they, again, tended to
8 only emphasize the positive and not provide
9 information about the negative in the context such
10 as people in the academic community were trying to
11 do.

12 BY MR. BECKWORTH:

13 Q. And being slow to disclose these risks had
14 an opposite effect, which was an increase in
15 prescribing of opioids for noncancer, chronic pain?

16 MR. ERCOLE: Objection to form.

17 THE WITNESS: Yeah. I can't speak to
18 the extent to which those behaviors led to increased
19 prescribing. I think that's a question for research.
20 I don't really know the answer to that.

21 But I can say that my opinion today is
22 that those -- that that balance between a positive
23 message and a negative message, the context about
24 who to select, what to try before going to opioids,
25 all of those -- all of those risk-related concepts

1 and the context of irreducible risk associated with
2 the use of opioid drugs, that tended to be neglected
3 in the marketing materials, and could have had an
4 impact in the way doctors perceived these drugs and
5 led to more prescribing.

6 BY MR. BECKWORTH:

7 Q. Now, in 1996, you published a review
8 article on opioid therapy titled "Opioid therapy for
9 chronic nonmalignant pain: A review of the critical
10 issues," in the Journal of Pain and Symptom
11 Management, correct?

12 A. Yes.

13 Q. In that paper, you elaborated on aberrant
14 drug-related behaviors that are associated with
15 addiction?

16 A. Yes.

17 Q. You agree that people who are opioid
18 addicted can sometimes engage in desperate behaviors
19 to obtain opioids, correct?

20 A. Yes.

21 Q. And desperate behaviors to maintain their
22 opioid supply if they need it?

23 A. People who are addicted?

24 Q. Yes, sir.

25 A. Yes. Yes, of course.

1 Q. You also agree that an opioid-addicted
2 individual might pretend to have pain in order to
3 obtain opioids?

4 A. Yes, of course.

5 Q. Or maintain an opioid supply?

6 A. Yes.

7 MR. ERCOLE: Objection to form.

8 BY MR. BECKWORTH:

9 Q. Is it also true that an opioid-addicted
10 individual might try to hide evidence of their
11 addiction from their doctor in order to obtain
12 opioids?

13 A. Yes.

14 Q. There is no objective measure like --
15 Let me start over.

16 You're a doctor, right?

17 A. Yes.

18 Q. If you want to know someone's temperature,
19 you have a means to check their temperature,
20 correct?

21 A. Right.

22 Q. If you want to know someone's pulse, you
23 can check their pulse?

24 A. That's correct.

25 Q. If you want to look at their blood oxygen

1 level, you can check that?

2 A. That's right.

3 Q. There's no such objective test to test for
4 opioid addiction?

5 A. That's right.

6 MR. ERCOLE: Objection to form.

7 THE WITNESS: Opioid addiction is a
8 brain disease with behavioral manifestations. And
9 the only way that one can make the diagnosis is by
10 monitoring behavior.

11 That was one -- that was the reason that
12 back in the early 1990s, I constructed a table of
13 so-called aberrant drug-related behavior and
14 published that first in a book chapter and then it
15 became published in many other places, and
16 ultimately even was used to create a measurement
17 tool.

18 That initial effort on my part to codify
19 all the different kinds of behaviors that a
20 physician might see was an effort to try to get an
21 educational tool so that physicians would understand
22 that they have to monitor drug-related behavior in
23 order to make an inference that the patient may have
24 the disease of addiction or even just to determine
25 the patient's abusing the drug and there needs to be

1 some additional control.

2 BY MR. BECKWORTH:

3 Q. And that's because it's true, isn't it,
4 that addiction's hard to diagnose?

5 MR. ERCOLE: Objection to form.

6 THE WITNESS: I believe that that's
7 true, yes.

8 BY MR. BECKWORTH:

9 Q. And generally the folks that specialize in
10 addiction diagnosis are psychiatrists?

11 A. That's right.

12 Q. And the treatment of addiction is complex
13 as well, correct?

14 A. That's correct.

15 Q. There are a lot of behaviors that someone
16 suffering from addiction might manifest that they
17 might try to hide from others?

18 A. That's true.

19 Q. Because addiction is a difficult disease?

20 A. Yes, it's --

21 MR. ERCOLE: Objection to form.

22 THE WITNESS: It's a very difficult
23 disease. It's a very serious disease.

24 BY MR. BECKWORTH:

25 Q. And if someone becomes addicted, while it

1 might be able to be treated, you can have addiction
2 for the rest of your life?

3 MR. ERCOLE: Objection to form.

4 THE WITNESS: I think the answer to that
5 is sort of complex because if a person has the
6 disease of addiction and it's been manifest,
7 they've -- in most cases they've declared themselves
8 as having a predisposition in the brain to have that
9 disease. There's a strong genetic component to that.

10 Once a person has a diagnosis of
11 addiction, then it should be clear to a health
12 professional that they have a capacity to relapse
13 into that addictive pattern of abuse again. If they
14 don't have access to the drug or they have a great
15 deal of social support or they have medication-
16 assisted treatment, they may never abuse the drug
17 again. But they always carry that capacity of
18 becoming addicted again, which was demonstrated by
19 their first diagnosis of addiction.

20 BY MR. BECKWORTH:

21 Q. And yet another reason why addiction is
22 very complex?

23 A. Yes.

24 Q. The consequences of addiction -- and you
25 referred to aberrant behavior -- those behaviors are

1 bad?

2 A. Yes, they're bad.

3 Q. They can be tragic?

4 A. Yes.

5 Q. They can lead to crime?

6 A. Yes.

7 Q. Death?

8 A. Yes.

9 Q. I've even seen some folks say that it could
10 lead to things like engaging in prostitution or
11 human trafficking?

12 A. Yes.

13 MR. ERCOLE: Objection to form.

14 BY MR. BECKWORTH:

15 Q. It can rip families apart?

16 A. Yes.

17 Q. It can cause people to lose their jobs?

18 A. Yes.

19 Q. Destroy marriages?

20 A. Yes.

21 Q. Destroy families?

22 A. Yes.

23 Q. Destroy communities?

24 A. Yes.

25 Q. It's serious?

1 A. It is.

2 Q. It's no laughing matter?

3 A. Right.

4 Q. It's just the opposite; do you agree?

5 A. I totally agree.

6 Q. So in your 1996 paper, one of the things
7 that you stated in there is that the data regarding
8 iatrogenic addiction from using opioids for chronic
9 noncancer pain are limited?

10 A. That's true.

11 Q. And that was true in 1996?

12 A. Yes.

13 Q. You also state in your paper that
14 controlled clinical trials of long-term opioid
15 therapy were still needed as of 1996?

16 A. Yes.

17 Q. You believed that when you wrote that paper?

18 A. Yes.

19 Q. As you sit here today, sir, can you say
20 with certainty what percentage of patients treated
21 with long-term opioids will develop the disease of
22 addiction?

23 MR. ERCOLE: Objection to form.

24 THE WITNESS: We know a great deal more
25 now in 2019 than we knew in 1996. And the question

1 is a bit complex and needs to be deconstructed
2 because one part of the question is, what's the
3 likelihood of addiction in patients who have no
4 prior history of substance abuse. That's an
5 important question.

6 Another question is, what's the
7 likelihood of addiction developing in patients who
8 have either a prior history of substance abuse or
9 have other risk factors for substance abuse, like
10 mental illness, for example. And the answer to
11 those questions are all different.

12 There has been just recently, last year,
13 a new study of the existing literature, a systematic
14 review and a so-called metaanalysis that looked at
15 all of the publications, all of the scientific
16 studies that evaluated patients with no prior
17 history of substance abuse who were given an opioid
18 for pain.

19 And that paper came up with the
20 percentage of about 4.7 percent risk of iatrogenic
21 addiction. But it noted that in the studies of that
22 group, the studies that existed had a range that was
23 from below 1 percent all the way up to over
24 20 percent.

25 So the studies out there are not

1 precise, and physicians have to -- have to recognize
2 that definitive data about risk doesn't exist.

3 And I'll just finish by saying that's
4 why for me, the message has always been to have a
5 clinical approach to patients who are taking opioid
6 drugs that include monitoring their behavior. And
7 that if their behavior demonstrates aberrancy,
8 meaning to say that they don't follow instructions
9 or they engage in problematic behavior, to do a
10 comprehensive reassessment of that patient and try
11 to make a diagnosis.

12 In some cases you would call that
13 addiction if there's enough reasons to believe the
14 person meets criteria for addiction. In some cases
15 it would be drug abuse. In some cases it might be
16 diversion. And only in that way can a clinician
17 manage that.

18 BY MR. BECKWORTH:

19 Q. So you deconstructed that answer, and I'm
20 reading it back. One of the things you said is:
21 "The studies out there are not precise and
22 physicians have to recognize that the definitive
23 data about risk doesn't exist," correct?

24 A. Yes. I think that's true.

25 Q. Definitive data about risk does not exist?

1 A. That's true.

2 Q. Even today in January of 2019?

3 A. Right.

4 Q. And that's not a change from 1996 or any
5 year prior?

6 A. Right. And what I would add to that is
7 definitive data don't exist, but over time, there
8 have been better data about the risk profile. So --
9 and knowing the risk profile, knowing the risk
10 factors that may predict it, allows clinicians to
11 act in the patient's best interest.

12 Q. So --

13 A. But to have a number in hand that says
14 patients with these characteristics have this rate
15 of addiction, those data are not precise enough in
16 the literature to inform medical practice.

17 Q. Even today?

18 A. Even today.

19 Q. And as more information has become
20 available, as you just described, we still find
21 ourselves -- over 20 years after the introduction of
22 OxyContin, we still find ourselves not being able to
23 describe that risk with certainty, correct?

24 A. Correct.

25 MR. ERCOLE: Objection to form.

1 THE WITNESS: That's correct.

2 BY MR. BECKWORTH:

3 Q. So going back to the question I asked you,
4 the question I asked you was, as you sit here today,
5 can you say with certainty what percentage of
6 patients treated with long-term opioids will develop
7 the disease of addiction?

8 MR. ERCOLE: Objection to form.

9 BY MR. BECKWORTH:

10 Q. Based on those qualifications, the answer
11 is no?

12 A. No.

13 MR. ERCOLE: Objection to form.

14 BY MR. BECKWORTH:

15 Q. No, I'm correct?

16 A. You are correct.

17 Q. Thank you. Now, we talked about your
18 papers for a minute. You believe that the drug
19 companies, some of them used your work to promote
20 opioids by referencing the positive statements you
21 made without providing all of the background,
22 analysis, and cautions that you also had in your
23 work, correct?

24 A. That's correct.

25 MR. ERCOLE: Objection to form.

1 BY MR. BECKWORTH:

2 Q. And because of that, use of your studies,
3 speeches, and papers in that way lacked balance?

4 MR. ERCOLE: Objection to form.

5 THE WITNESS: That's correct.

6 MS. SPENCER: One clarification. Okay.
7 Use of the studies lacked balance. Not that the
8 papers themselves lacked balance?

9 MR. BECKWORTH: Yes.

10 BY MR. BECKWORTH:

11 Q. To be clear, use of your papers by the
12 pharmaceutical industry in a way that didn't show
13 all the good and bad lacked balance?

14 A. Yes.

15 MR. EHSAN: Objection to form.

16 MR. ERCOLE: Objection to form.

17 BY MR. BECKWORTH:

18 Q. And you're troubled by that?

19 A. Yes.

20 Q. Now, one example that you provide in your
21 declaration is something called myths about opioids,
22 which was a document that Purdue used in its
23 marketing efforts?

24 A. Yes.

25 Q. That was around 2011, correct?

1 A. Yes.

2 MS. SPENCER: Are we at paragraph 34?

3 MR. BECKWORTH: Yes.

4 THE WITNESS: It's okay if I look at
5 this, right?

6 BY MR. BECKWORTH:

7 Q. Yes. And I'm not going to go through
8 specific questions right now. You reference that
9 document as one that cited you and didn't give all
10 the right disclosures of risk and the negative
11 consequences of using opioids for the treatment of
12 noncancer chronic pain, correct?

13 A. That's correct.

14 Q. Also in 1997, Purdue published a brochure
15 that you cite in your declaration as saying that
16 opioid therapy was appropriate, safe, and effective
17 on a long-term basis for selective patients.

18 And in that same document, Purdue said
19 that the risk of taking an opioid and getting
20 addicted for chronic pain was less than 1 percent?

21 Do you understand what I'm talking
22 about?

23 A. Yes.

24 Q. And do you believe that saying that the
25 risk of addiction is less than 1 percent when taking

1 an opioid for chronic pain is complete and accurate?

2 A. Yeah. That's inaccurate.

3 Q. It's inaccurate because it doesn't give all
4 the types of data that we just talked about?

5 A. That's right.

6 Q. And you admit that it doesn't provide all
7 the warnings that are necessary?

8 A. That's correct.

9 Q. And you also would agree that if a
10 physician were to read this and not be experienced
11 in addiction diagnosis and treatment, that could
12 cause the physician to not be able to make the right
13 decision?

14 MR. ERCOLE: Objection to form.

15 THE WITNESS: If by "the right
16 decision," you're saying that seeing information
17 like this might make inexperienced physicians more
18 likely to prescribe, and particularly more likely to
19 prescribe in situations associated with higher risk,
20 then the answer is yes.

21 BY MR. BECKWORTH:

22 Q. And it might also cause such a physician to
23 not see the warning signs associated with someone
24 who might actually be an addict?

25 MR. ERCOLE: Objection to form.

1 THE WITNESS: Yes. I think that's true
2 too.

3 BY MR. BECKWORTH:

4 Q. And as we just talked about a moment ago,
5 you agreed that when we started in 1996 with one of
6 your papers, there were fears about risk associated
7 with using opioids for chronic pain?

8 A. Yes.

9 MR. ERCOLE: Objection to form.

10 BY MR. BECKWORTH:

11 Q. And anytime you diminish those fears
12 without talking about the risk associated with them,
13 you have the possibility that more prescribing will
14 occur?

15 MR. ERCOLE: Objection to form.

16 THE WITNESS: I think that that's true.

17 BY MR. BECKWORTH:

18 Q. Now, you also have stated that this paper
19 we're discussing at the moment did not indicate that
20 opioids should be tried after other reasonable
21 efforts at pain management have been unsuccessful,
22 correct?

23 MS. SPENCER: I'm sorry. Which paper?
24 Because we went from his paper to then the Purdue
25 documents.

1 MR. BECKWORTH: Sorry. Yes.

2 BY MR. BECKWORTH:

3 Q. Your attorney wants me to make sure I'm not
4 talking about your papers, and to be clear, I'm not.
5 I'm talking about the 1997 Purdue paper that you
6 mention. You state that that paper did not indicate
7 that opioids should be tried after other reasonable
8 efforts at pain management were unsuccessful,
9 correct?

10 A. That's correct.

11 Q. And you understand there's something called
12 the WHO, or World Health Organization, ladder for
13 treatment?

14 A. Yes.

15 Q. Correct?

16 A. Yes.

17 Q. Strong opioids should never be used in the
18 first instance for moderate pain; do you agree?

19 A. Yes. The WHO analgesic ladder created in
20 the mid '80s pertained to cancer pain. It never was
21 meant to refer to noncancer pain. It was adapted to
22 noncancer pain in ways that I've been concerned
23 about over the years.

24 And when I lectured about the WHO ladder,
25 I would always mention that the WHO ladder was not

1 intended to be about noncancer pain. And the WHO
2 ladder, for example, doesn't advise trying other
3 modalities for moderate to severe pain before trying
4 opioids. Just the opposite.

5 It says if the patient has moderate or
6 severe chronic pain, opioids are the first-line
7 drug. So the WHO ladder specifically contradicts
8 the guidelines that I believed in even back in 1986
9 when I wrote the first set.

10 Q. For noncancer pain?

11 A. For noncancer pain.

12 Q. So let's go back through that and, to use
13 your words, deconstruct because I think that's a
14 long answer you gave.

15 The WHO ladder was for cancer pain,
16 correct?

17 A. Yes. That's correct.

18 Q. And I believe you testified earlier -- I'm
19 going to use my words -- correct me if I'm wrong --
20 but I believe you testified earlier that there are
21 different considerations when you're dealing with
22 cancer or end-of-life pain treatment, correct?

23 MR. ERCOLE: Objection to form.

24 THE WITNESS: That's correct.

25

1 BY MR. BECKWORTH:

2 Q. That's what you said, correct?

3 A. Correct.

4 Q. Is it your testimony that for anyone to use
5 the World Health Organization ladder and portray it
6 as applying to noncancer, non-palliative chronic
7 pain, that that's wrong?

8 MR. ERCOLE: Objection to form.

9 THE WITNESS: That would be wrong
10 without context, without providing the information
11 that this approach is being modified or adapted to a
12 population that it wasn't originally developed to
13 address.

14 BY MR. BECKWORTH:

15 Q. Because the WHO ladder was never intended
16 to support a slogan like, Start with and stay with
17 an opioid for noncancer chronic pain, was it?

18 A. No.

19 MR. ERCOLE: Objection to form.

20 BY MR. BECKWORTH:

21 Q. Your answer was "no"?

22 A. "No."

23 Q. And for a drug company to use that ladder
24 for such a slogan or approach would be wrong?

25 MR. ERCOLE: Objection to form.

1 THE WITNESS: It would trouble me if the
2 ladder without any statement of context, without
3 talking about how it was being modified, if that was
4 used to illustrate that slogan, that would not be --
5 that would be wrong. That's clearly not what the
6 ladder was intended to do.

7 BY MR. BECKWORTH:

8 Q. And you stated earlier that you were
9 concerned that that was exactly what was happening?

10 MR. ERCOLE: Objection to form.

11 THE WITNESS: Stated earlier? I'm not
12 sure what you're referring to.

13 BY MR. BECKWORTH:

14 Q. You stated -- Let me go back. I heard you
15 say -- correct me if I'm wrong -- that at some
16 point, you were concerned that the WHO ladder was
17 being adopted to be used in the noncancer chronic
18 pain treatment.

19 Did you say that?

20 A. Yes, that's true.

21 MR. ERCOLE: Objection to form.

22 BY MR. BECKWORTH:

23 Q. And adopted by who?

24 A. Well, I can't be precise with that answer
25 because it was happening a lot in the '90s.

1 Q. A lot?

2 A. A lot. And if it was happening -- if it
3 was done by the drug companies to promote an idea or
4 for a product, that would not be proper, in my view,
5 in the same way that if it was done by colleagues,
6 I wouldn't agree with it.

7 It was never meant to portray a
8 guideline for the treatment of chronic noncancer
9 pain.

10 Q. And was it meant for a drug company to
11 teach to your colleagues that this is what the WHO
12 ladder was for?

13 MR. ERCOLE: Objection to form.

14 THE WITNESS: Not the chronic noncancer
15 pain. It was appropriate to teach chronic cancer
16 pain.

17 BY MR. BECKWORTH:

18 Q. So it could be wrong for a pharmaceutical
19 company who makes or sells opioids to take the WHO
20 ladder and educate doctors that that ladder applied
21 to noncancer pain, correct?

22 A. Correct.

23 MR. ERCOLE: Objection to form.

24 THE WITNESS: Unless, as I said, I can't
25 imagine that with the proper warnings and context it

1 could be a tool. But without those, it's not the
2 right thing to do.

3 BY MR. BECKWORTH:

4 Q. Now, in paragraph 14 of your declaration,
5 you stated that on December 12, 1995, Purdue Pharma,
6 L.P. introduced OxyContin.

7 A. Yes.

8 Q. And after 1996, do you believe that Purdue
9 aggressively marketed the drug OxyContin?

10 A. Yes.

11 Q. In your opinion, based on your -- Start
12 over.

13 Based on your experience and
14 understanding of the facts as you know them in your
15 career, have you ever seen a company market an
16 opioid for noncancer chronic pain as aggressively as
17 Purdue had?

18 A. No. Purdue did it most aggressively.

19 Q. To your knowledge, prior to 1996, had any
20 drug company encouraged the use of an opioid for
21 noncancer chronic pain by people who were not pain
22 specialists?

23 A. Not to my knowledge, no.

24 Q. When OxyContin hit the market, did we have
25 an opioid crisis in the United States of America?

1 MR. ERCOLE: Objection to form.

2 THE WITNESS: So to the extent that we
3 had and have a public health problem, it wasn't
4 present in 1995 and '96.

5 BY MR. BECKWORTH:

6 Q. Based on your experience and knowledge of
7 the facts and working in the pain field, in December
8 of 1995 when OxyContin was approved, did this
9 country have a public health problem related to
10 prescription opioids for noncancer chronic pain
11 treatment?

12 MR. ERCOLE: Objection to form.

13 THE WITNESS: It wasn't widely
14 considered to be so, no. There always have been
15 drugs that have been diverted and abused,
16 prescription drugs. That has always been the case
17 ever since they were available.

18 But at that time, it was considered to
19 be small relative to the problem, for example, of
20 heroin abuse.

21 BY MR. BECKWORTH:

22 Q. And you understand, based on your
23 experience, that prescribing of opioids for
24 nonchronic cancer pain increased after OxyContin hit
25 the market; would you agree?

1 A. Yes.

2 MR. ERCOLE: Objection to form.

3 BY MR. BECKWORTH:

4 Q. And I went over this earlier. I used some
5 terms like "target" and "detailing"; do you remember
6 that?

7 A. Yes.

8 Q. And you are aware that the drug companies
9 in this case used sales representatives to interface
10 with treating physicians, correct?

11 A. Yes.

12 MR. ERCOLE: Objection to form.

13 MR. BECKWORTH: I'm going to hand you a
14 document we'll label as Exhibit 21.

15 THE WITNESS: Yes.

16 (Portenoy Exhibit 21 was marked
17 for identification.)

18 BY MR. BECKWORTH:

19 Q. Exhibit 21 is a document produced by Purdue
20 in the State of Oklahoma's case.

21 Do you see that, sir?

22 A. Yes.

23 Q. And this shows the average monthly
24 prescriptions on the left-hand side of OxyContin.
25 And on the bottom, it's the average monthly calls

1 upon doctors.

2 Do you see that?

3 A. Yes.

4 Q. And the title of this page says what?

5 A. "Total prescription level is highly
6 correlated to call activity."

7 MR. BECKWORTH: Now, I'm going to hand
8 you an exhibit we'll label as Exhibit 22 to your
9 deposition.

10 (Portenoy Exhibit 22 was marked
11 for identification.)

12 BY MR. BECKWORTH:

13 Q. Exhibit 22, while you look at it, is from a
14 document produced by Purdue. This document on
15 page 10, which is the first page you have, says
16 "Targeting the high prescribers."

17 Do you see that?

18 A. Yes.

19 Q. And if you look at it, it shows that for
20 called-upon doctors during this time period, there
21 were 58,448 doctors.

22 Do you see that?

23 A. Yes.

24 Q. And then it shows the number of
25 prescriptions written between January and May 2010

1 by called-upon doctors. And it shows how many?

2 A. 2,010,233.

3 Q. And then it shows next to that, that during
4 that time, there were how many called-upon doctors?

5 A. 231,468.

6 Q. And that was an average of 34 prescriptions
7 per doctor called upon, correct?

8 A. That's correct.

9 Q. Now, if you look below that, it lists
10 totals for non-called-upon doctors, right?

11 A. Right.

12 Q. And there we see there were 256,337 doctors
13 that weren't called upon?

14 A. Correct.

15 Q. How many drug prescriptions for opioids did
16 they prescribe?

17 MR. ERCOLE: Objection to form.

18 THE WITNESS: 1,176,191.

19 BY MR. BECKWORTH:

20 Q. The number of calls between January and
21 May 2010 were how many?

22 A. Were zero.

23 Q. And the prescriptions per doctor were how
24 many?

25 A. Four.

1 MR. COLEMAN: Objection to form.

2 BY MR. BECKWORTH:

3 Q. How many?

4 A. Four.

5 Q. So quite a bit less?

6 A. Yes.

7 Q. Substantially less?

8 A. Yes.

9 MR. ERCOLE: Objection to form.

10 BY MR. BECKWORTH:

11 Q. Would you agree?

12 A. Yes, I do.

13 Q. Now, if you look at the next page, you see
14 "Total prescriptions" there on the left and called-
15 upon data on the bottom, correct?

16 A. Yes.

17 Q. And the title of that page says "Overall
18 called-on M.D.s' total prescription volumes slightly
19 increased while non-called-on M.D.s' total
20 prescription volume decreased," correct?

21 A. Yes.

22 Q. Thank you. So according to these documents
23 that you've seen, according to Purdue, there is a
24 correlation between calling upon a doctor who is a
25 target and prescribing conduct?

1 MR. ERCOLE: Objection to form.

2 THE WITNESS: Yes.

3 BY MR. BECKWORTH:

4 Q. It says it right there in black and white?

5 A. That's true.

6 Q. Now, you stated in your declaration that
7 you understood that drug company defendants promoted
8 their drugs aggressively to primary care physicians?

9 MR. ERCOLE: Objection to form.

10 THE WITNESS: Yes.

11 BY MR. BECKWORTH:

12 Q. You also stated that between 1987 and 2005,
13 the prevalence of long-term opioid use increased by
14 between 61 and 135 percent?

15 A. Yeah. That was the data cited in the
16 declaration. That's right.

17 Q. Based upon your knowledge and experience,
18 by the late 1990s, at least, you were aware that
19 serious adverse outcomes related to opioid
20 prescribing for noncancer chronic pain were
21 occurring?

22 A. Yes --

23 MR. ERCOLE: Objection to form.

24 THE WITNESS: -- that's true.

25

1 BY MR. BECKWORTH:

2 Q. We had serious hot spots floating up in
3 different parts of the country?

4 MR. ERCOLE: Objection to form.

5 THE WITNESS: That is true, yes.

6 BY MR. BECKWORTH:

7 Q. Abuse in the -- diversions were occurring?

8 A. Yes.

9 Q. And addiction rates were rising?

10 A. That's true.

11 MR. ERCOLE: Objection to form.

12 BY MR. BECKWORTH:

13 Q. And you are aware -- I'll ask you this.

14 Are you aware that in 2003, the United States GAO
15 office issued a report about the role of Purdue in
16 creating some of these problems?

17 A. No, I wasn't aware of that.

18 Q. Have you ever read that report?

19 A. Not that I recall, no.

20 Q. You are aware that in 2007, Purdue pled
21 guilty to a federal crime?

22 A. Yes.

23 Q. And as we established earlier, three of its
24 executives pled guilty to a federal crime?

25 A. Yes.

1 Q. Related to misbranding related to OxyContin?

2 A. Yes.

3 Q. And as we talked about earlier, you know
4 that in 2008, Cephalon entered into a guilty plea
5 for misconduct related to, among other things,
6 marketing Actiq?

7 MR. ERCOLE: Objection to form.

8 THE WITNESS: Yes.

9 BY MR. BECKWORTH:

10 Q. And as we discussed earlier today -- I
11 showed you an exhibit on this -- Johnson & Johnson's
12 subsidiary Tasmanian Alkaloids grew the Norman
13 poppy?

14 A. Yes.

15 Q. And as you saw in that document, J&J
16 actually gave a medal to a scientist for a specific
17 creation of a poppy because that invention led to
18 the growth of OxyContin?

19 MR. EHSAN: Objection to form.

20 THE WITNESS: Yes. That's what the
21 document said.

22 BY MR. BECKWORTH:

23 Q. You understand that oxycodone is the active
24 pharmaceutical ingredient in OxyContin?

25 A. That's correct.

1 Q. And you understand that in addition to
2 Purdue, other companies sell generic versions of
3 OxyContin?

4 A. Yes.

5 MR. ERCOLE: Objection to form.

6 BY MR. BECKWORTH:

7 Q. Now, one of the things you talk about in
8 paragraph 37 of your declaration is the American
9 Pain Society and AAPM consensus statement.

10 Do you recall that?

11 A. Yes.

12 MS. SPENCER: Give me just a minute to
13 get to the spot. Did you say paragraph 37?

14 MR. BECKWORTH: I believe that's it.

15 THE WITNESS: Not my 37.

16 MS. SPENCER: Not my 37 either.

17 MR. BECKWORTH: Whichever one is the
18 American Pain Society statement. It's fine if you
19 don't have it; we can talk about it.

20 MS. SPENCER: I'd rather have it open.
21 Is it 17?

22 MS. CARTMELL: I think so.

23 MR. BECKWORTH: Sure. We can start
24 here. Thank you. There's other places, but that's
25 fine.

1 BY MR. BECKWORTH:

2 Q. You were a board member, as we discussed
3 earlier, of the American Pain Society, correct?

4 A. Yes.

5 Q. And you were president for a one-year term?

6 A. Yes.

7 Q. You also were a board member of the
8 American Pain Foundation from 2000 to 2012, correct?

9 A. Yes.

10 Q. During the time you were on the board, as
11 we discussed earlier, the APF was funded mostly by
12 pharmaceutical company grants?

13 A. Yes.

14 Q. And you stated that was a concern of the
15 APF board for many years?

16 MR. ERCOLE: Objection to form.

17 THE WITNESS: That's correct, yes.

18 BY MR. BECKWORTH:

19 Q. You also stated that the APF didn't focus
20 on the rising problem of opioid overdose?

21 MR. ERCOLE: Objection to form.

22 THE WITNESS: That's true.

23 BY MR. BECKWORTH:

24 Q. And your belief about that is what?

25 A. Well, the APF wrote grants and did projects

1 that were intended to provide support to patients
2 who had pain and their families or to provide
3 information to the public.

4 So the projects they did were only
5 projects for which grants could be funded.
6 And because the reliance of the APF on the
7 pharmaceutical industry was so high, they were not
8 able to access -- management was not able to access
9 funding for education focused on abuse liability or
10 risk of addiction or concern about overdose.

11 It was included in some of the materials
12 that were written, but there was no focused
13 educational program comparable to the other kinds of
14 projects they did because they could only do the
15 projects that were funded through the grants that
16 they wrote.

17 Q. And you believe that the dependence on that
18 type of funding may have influenced the ability of
19 APF to take positions that were contrary to the
20 wishes of the pharmaceutical industry?

21 MR. ERCOLE: Objection to form.

22 THE WITNESS: Yes.

23 MR. BECKWORTH: I'm going to hand you --
24 if you'll pass the extra copies to your lawyer --
25 Exhibit 23, sir.

1 (Portenoy Exhibit 23 was marked
2 for identification.)

3 BY MR. BECKWORTH:

4 Q. I've just handed you Exhibit 23, which is a
5 copy of "The use of opioids for the treatment of
6 chronic pain," correct?

7 A. Yes.

8 Q. Now, is this what you refer to as the
9 consensus statement?

10 A. Yes.

11 Q. This document was published by the American
12 Academy of Pain Medicine and the American Pain
13 Society?

14 A. That's correct.

15 Q. The committee chair was David Haddox?

16 A. Yes.

17 Q. You know that David Haddox ultimately went
18 to work for Purdue?

19 A. Yes.

20 Q. You're listed here as a consultant?

21 A. Yes.

22 Q. Why are you listed as a consultant?

23 A. After the committee did this work, I was
24 sent the document and asked if I had any comments.

25 Q. So as consultant work, were you paid for

1 that?

2 A. No.

3 Q. You did look at it for comments?

4 A. Yes.

5 Q. Did you make comments?

6 A. I simply don't remember.

7 Q. You didn't stop this document from going --

8 A. No.

9 Q. I'm sorry. I didn't finish. You didn't
10 stop the document from being published?

11 A. No.

12 Q. Now, you have stated that the consensus
13 statement presented a very favorable perspective as
14 it related to risk regarding the use of opioids for
15 nonchronic -- sorry -- noncancer chronic pain?

16 A. Yes.

17 Q. You believe the consensus statement may
18 have implicitly promoted wider use of opioids?

19 A. Yes.

20 MR. ERCOLE: Objection to form.

21 BY MR. BECKWORTH:

22 Q. Do you also believe the consensus statement
23 differed from the more lengthy articles that you put
24 out that talked about the risk attendant to using
25 opioids in this manner?

1 A. Yes. The purpose was to create -- I think
2 the purpose was to create a very shorthand, easily
3 readable document for general consumption.

4 Q. You also believe, correct, that the
5 consensus statement was widely disseminated?

6 A. Yes.

7 Q. Do you recall seeing it distributed at pain
8 society meetings?

9 A. Yes.

10 Q. You also believe it was distributed by drug
11 company representatives to prescribers?

12 MR. ERCOLE: Objection to form.

13 THE WITNESS: I believe so, yes.

14 BY MR. BECKWORTH:

15 Q. And do you believe that was done for a
16 purpose?

17 MR. ERCOLE: Objection to form.

18 THE WITNESS: Well, I can't really speak
19 to that. I imagine there was a purpose, but no one
20 ever discussed that purpose with me.

21 BY MR. BECKWORTH:

22 Q. In your declaration, do you state you
23 believe it was done to help promote their products?

24 MR. ERCOLE: Objection to form.

25 THE WITNESS: Yes.

1 BY MR. BECKWORTH:

2 Q. Yes?

3 A. Yes.

4 Q. And you also are familiar with a book
5 called "Responsible Opioid Prescribing"?

6 A. Um --

7 Q. It's not mentioned in your declaration.
8 I'm just asking if you're familiar with the book.

9 A. Who is the author?

10 Q. Fishman.

11 A. Yes.

12 Q. And in that book, the consensus statement
13 was included as an appendix?

14 A. Yes.

15 MR. ERCOLE: Object to the form.

16 BY MR. BECKWORTH:

17 Q. Did you know that the AAPM continued
18 disseminating the consensus statement all the way
19 until 2012?

20 MR. ERCOLE: Objection to form.

21 THE WITNESS: I did know that.

22 BY MR. BECKWORTH:

23 Q. You did do work with the AAPM?

24 A. Aside from this, I don't believe I did.

25 Q. Have you ever asked anybody to sunset,

1 meaning stop, using the consensus statement?

2 A. No.

3 Q. Do you think that document should still be
4 used?

5 A. No, not today.

6 Q. And it shouldn't have been used in 2012
7 either?

8 MR. ERCOLE: Objection to form.

9 THE WITNESS: Not without context.

10 BY MR. BECKWORTH:

11 Q. You -- We've talked about this a little bit
12 already. But you state that your work was not
13 always presented by others with the description and
14 study of risk attendant with opioid prescribing that
15 you had worked on, correct?

16 MR. ERCOLE: Objection to form.

17 THE WITNESS: Yes.

18 BY MR. BECKWORTH:

19 Q. Do you believe that the impact of using
20 your work/studies/book chapters without disclosing
21 all these attendant risks lacked balance?

22 MR. ERCOLE: Objection to form.

23 THE WITNESS: Yes. Yes, I do.

24 BY MR. BECKWORTH:

25 Q. You understand that oftentimes drug company

1 defendants would have their sales reps interface
2 with doctors where they would take them to dinner or
3 to lunch?

4 MR. ERCOLE: Objection to form.

5 THE WITNESS: I don't have any specific
6 knowledge about how often that happened and when it
7 stopped happening and when it started. So as a
8 general concept, at least in the past, I think that
9 occurred. But I don't have any specifics about it.

10 BY MR. BECKWORTH:

11 Q. And you also understand that there were
12 drug company seminars, that there were -- Let me
13 start over.

14 You understand that there were seminars
15 and conferences hosted by different third-party
16 groups that the pharmaceutical companies would help
17 fund?

18 A. Yes.

19 MR. ERCOLE: Objection to form.

20 BY MR. BECKWORTH:

21 Q. And during those types of seminars, many
22 doctors and health care providers would come and
23 listen to folks like yourself speak?

24 A. Yes.

25 Q. And they could also get materials from drug

1 companies?

2 A. Yes.

3 MR. ERCOLE: Objection to form.

4 BY MR. BECKWORTH:

5 Q. You believe in the marketing that the
6 defendants did, wherever they used your work, they
7 should have always stated that addiction is a
8 disease?

9 MR. ERCOLE: Objection to form.

10 THE WITNESS: I believe that the -- it
11 was important even from the earliest days to provide
12 context to the positive statements and arguments
13 that I and others were making about opioids. We had
14 an interest in trying to teach doctors to have less
15 fear of opioids, especially fears that were not
16 based on the science.

17 But at the same time, even in the
18 earliest days of -- in my writings, I always pointed
19 out that there was a need for a context to that,
20 there was a need to understand that risk was
21 irreducible. There was always going to be some
22 risk. And because that risk was always there, it
23 was necessary to consider other types of pain
24 management before considering an opioid.

25 It was important to select a patient and

1 if the patient had a high risk of abuse or
2 addiction, to not prescribe. And it was essential
3 to monitor drug-related behavior during prescribing
4 so that if a patient began to develop aberrant
5 behavior, the doctor could pick it up and either get
6 it under control or stop prescribing. Those
7 messages weren't included.

8 BY MR. BECKWORTH:

9 Q. Were not included?

10 A. They were not included.

11 Q. And it was wrong to not include all of
12 those messages when a third party would be promoting
13 the use of an opioid for noncancer chronic pain
14 treatment, correct?

15 MR. ERCOLE: Objection to form.

16 THE WITNESS: If the third party was
17 participating or creating continuing medical
18 education, then this would have to be with
19 independent -- an independent speaker who would
20 submit slides to another independent party for
21 review. There were lots of rules about that.

22 But there were also conferences that
23 were called promotional conferences that were not
24 CME. They didn't carry credit for doctors. And to
25 the extent that messages like that occurred at those

1 conferences without context and without warnings,
2 that was not the right thing to do.

3 BY MR. BECKWORTH:

4 Q. It would be misleading?

5 A. It would be misleading, yes.

6 MR. ERCOLE: Objection to form.

7 BY MR. BECKWORTH:

8 Q. I was spoken over.

9 It would be misleading to conduct those
10 kind of conferences and provide that information
11 without disclosing all of the risk information you
12 just described, correct?

13 MR. ERCOLE: Same objection.

14 THE WITNESS: Yes.

15 BY MR. BECKWORTH:

16 Q. Correct?

17 A. Correct.

18 MR. ERCOLE: Same objection.

19 BY MR. BECKWORTH:

20 Q. Now, you mentioned aberrant behaviors.
21 We all pronounce that a little bit differently.
22 Aberrant behaviors are things we talked about
23 earlier like stealing, lying, cheating, committing
24 crimes, correct?

25 A. Yes.

1 Q. And they can vary in degree?

2 A. Yes.

3 Q. While aberrant behavior is not always
4 equivalent to addiction, they can be important signs
5 in assessing addiction; do you agree?

6 A. I agree.

7 Q. Is it true that marketing that would tell a
8 physician to ignore or discount signs of aberrant
9 behavior was wrong?

10 MR. ERCOLE: Objection to form.

11 THE WITNESS: If marketing took that
12 form, yes, that would be wrong.

13 BY MR. BECKWORTH:

14 Q. And any marketing that would tell a patient
15 or their family to not worry about the risk of
16 addiction would be wrong too?

17 MR. ERCOLE: Objection to form.

18 THE WITNESS: I think that -- I would
19 just say that that's a complicated question because
20 everybody was already worried about addiction. That
21 was the way things were evolving when these drugs
22 became available. The concern about addiction was
23 so high that it was interfering with the ability of
24 doctors to treat even cancer pain and postoperative
25 pain.

1 So it's very important that balance be
2 in the messages from day one. I really do believe
3 that. But at the same time, at least in these early
4 years, there was an important -- there was high
5 importance to try to reassure physicians that some
6 of their expectations that they had learned about
7 addiction weren't true.

8 As I said earlier today, as the public
9 health problem of abuse, addiction, and overdose
10 increased during the 2000s, it became more important
11 that those messages be included. And academic
12 people like myself, the professional societies,
13 essentially began to, what I've called recalibrate
14 their messages, and include more messages about risk
15 and risk assessment and diagnosis of addiction and
16 treatment of addiction and what aberrant behavior is.

17 And that's the time during which the
18 pharmaceutical companies in my view really needed to
19 step up and include a balanced message, and to the
20 extent they didn't, that was wrong.

21 BY MR. BECKWORTH:

22 Q. They needed to step up and include a
23 balanced message but they didn't?

24 MR. ERCOLE: Objection to form.

25 THE WITNESS: Right.

1 MR. ERCOLE: Mischaracterizes testimony.

2 BY MR. BECKWORTH:

3 Q. Is it your testimony that they needed to
4 step up and provide a more balanced message, but
5 failed to do so?

6 MR. ERCOLE: Objection to form.

7 THE WITNESS: Yes, I believe that's
8 true.

9 BY MR. BECKWORTH:

10 Q. Is it also true that they failed to go back
11 and correct misinformation that had been given
12 earlier?

13 MR. ERCOLE: Objection to form.

14 THE WITNESS: Yes. That's -- to me,
15 that's two sides of the same coin.

16 BY MR. BECKWORTH:

17 Q. And they didn't do it?

18 A. No.

19 MR. ERCOLE: Same objection.

20 BY MR. BECKWORTH:

21 Q. No, they did not do it?

22 A. No, they did not.

23 Q. Now, we talked a little bit earlier about
24 addiction being difficult to assess.

25 Do you remember that?

1 A. Yes.

2 Q. There's no objective, easy test like a
3 thermometer?

4 A. Yes.

5 Q. It takes specialized training?

6 A. So that's a complex question as well.
7 I think it takes specialized training to make a
8 diagnosis, a psychiatric diagnosis of addiction.

9 It takes training that I think is within
10 the purview of any physician to identify aberrant
11 behavior and ask the question: Does this aberrant
12 behavior rise to the level of addiction as a likely
13 diagnosis.

14 And that's something that any physician
15 who prescribes opioids has to take on as an
16 obligation: to monitor the behavior and to decide
17 whether or not the behavior they're observing rises
18 to the level that that could represent addiction.

19 Q. And you agree that a primary care physician
20 generally is not trained in the psychiatric
21 diagnosis of addiction?

22 MR. ERCOLE: Objection to form.

23 THE WITNESS: Yes.

24 BY MR. BECKWORTH:

25 Q. And we saw since 1996 that due to the

1 marketing efforts made by the pharmaceutical
2 industry, primary care physicians were targeted,
3 weren't they?

4 A. Yes.

5 MR. ERCOLE: Objection to form.

6 BY MR. BECKWORTH:

7 Q. They were targeted to proscribe opioids for
8 noncancer chronic pain?

9 MR. ERCOLE: Objection to form.

10 THE WITNESS: Yes, that's true.

11 BY MR. BECKWORTH:

12 Q. And when you're dealing with folks that
13 aren't pain specialists and aren't trained in
14 addiction, there's a need to make sure that they're
15 educated properly?

16 THE WITNESS: Yes.

17 MR. ERCOLE: Objection to form.

18 BY MR. BECKWORTH:

19 Q. Do you agree with that?

20 A. Yes.

21 MR. ERCOLE: Same objection.

22 BY MR. BECKWORTH:

23 Q. So to give that subgroup of the prescribing
24 universe incomplete information about the risk and
25 problems associated with opioid therapy for

1 nonchronic cancer pain, that's a problem?

2 MR. ERCOLE: Objection to form.

3 THE WITNESS: That's correct. And in my
4 view, it became a problem when it became clear that
5 the public health problem, the overarching concern
6 about abuse, addiction, and overdose that was
7 affecting the country, that needed to draw the
8 change in the message at that point.

9 BY MR. BECKWORTH:

10 Q. They should have always -- "they" being the
11 drug companies --

12 MS. SPENCER: Can I just take a quick
13 break. I don't want to interrupt. But I just got
14 this.

15 MR. BECKWORTH: Let's go off the record.

16 THE VIDEO OPERATOR: Off the record,
17 3:11.

18 (Discussion off the record.)

19 (Recess at 3:11 p.m.,
20 resumed at 3:31 p.m.)

21 THE VIDEO OPERATOR: We're back on the
22 record, 3:31.

23 BY MR. BECKWORTH:

24 Q. Now, sir, you understand that there was a
25 term called "pseudoaddiction" that started to appear

1 in the 1989-1990 time frame?

2 A. Yes.

3 Q. And that term was coined by Weissman and
4 Haddox?

5 A. Yes.

6 Q. And David Haddox ended up going to work for
7 Purdue?

8 A. Yes.

9 Q. He worked there for a long time?

10 A. Yes.

11 Q. You've stated that this term was used to
12 describe types of aberrant behavior such as
13 complaints for higher doses, frequent calls,
14 demands, and the like?

15 MR. ERCOLE: Objection to form.

16 THE WITNESS: Yes.

17 BY MR. BECKWORTH:

18 Q. And that pseudoaddiction indicates that
19 those things by themselves aren't signs of addiction?

20 MR. ERCOLE: Objection to form.

21 MS. SPENCER: Are we on paragraph 44?

22 MR. BECKWORTH: Yes.

23 MS. SPENCER: I'd like him to be able to
24 follow along.

25 MR. BECKWORTH: Sure.

1 THE WITNESS: Sorry.

2 MR. BECKWORTH: Yes. That's where
3 that's discussed.

4 BY MR. BECKWORTH:

5 Q. I'll ask you a new question.

6 A. Yes.

7 Q. Sir, the idea behind pseudoaddiction is
8 that when a person presented with some signs -- some
9 of these signs of aberrant behavior, the issue might
10 be that they're actually still in need of pain
11 treatment and a higher dose?

12 A. Yes, that's true.

13 MR. ERCOLE: Objection to form.

14 BY MR. BECKWORTH:

15 Q. We now know that primary care doctors
16 should not have been taught to give higher doses of
17 opioids to patients that appeared to be addicted?

18 MR. ERCOLE: Objection to form.

19 THE WITNESS: That's true.

20 BY MR. BECKWORTH:

21 Q. We know now, do we not, that primary care
22 doctors should have been taught to carefully assess
23 patients with aberrant drug-taking behavior for the
24 possibility of addiction?

25 A. Yes, that's true.

1 MR. ERCOLE: Objection to form.

2 BY MR. BECKWORTH:

3 Q. And if they thought they might be addicted,
4 to refer them to an addiction specialist?

5 A. If that's possible, yes.

6 Q. It's also true, is it not, that you now
7 believe that giving -- Let me start over.

8 It's also true that giving higher doses
9 of opioids to patients suffering from opioid
10 addiction is dangerous?

11 A. If the disease of addiction is active and
12 the patient's engaging in serious aberrant behavior,
13 yes, that would be dangerous.

14 Q. We also know that opioid-addicted patients
15 could more easily die from respiratory depression if
16 they are in active addiction and given higher doses
17 of opioids?

18 A. Yes, that's true.

19 Q. Based upon your personal experience, can
20 you state whether or not you agree that the
21 dissemination of the concept of pseudoaddiction by
22 defendants without also attaching clear messaging
23 about the appropriate response to aberrant behaviors
24 could have led prescribers to continue opioid
25 therapy or even raise dosage when it should have

1 been tapered down or stopped?

2 MR. ERCOLE: Objection to form.

3 THE WITNESS: Yes, I would agree with
4 that.

5 BY MR. BECKWORTH:

6 Q. You believe though that this, in fact,
7 happened?

8 A. Yes.

9 MR. ERCOLE: Objection to form.

10 BY MR. BECKWORTH:

11 Q. And you believe that people died as a
12 result?

13 MR. ERCOLE: Same objection.

14 THE WITNESS: I can't cite specific
15 examples but I think it would be a risky thing to do.

16 BY MR. BECKWORTH:

17 Q. Because death could occur?

18 MR. ERCOLE: Object to form.

19 THE WITNESS: Because death could occur
20 if the dose is increased and the patient is in an
21 addictive pattern of abuse, yes.

22 BY MR. BECKWORTH:

23 Q. Now, one of the things that you state in
24 paragraph 43 of your declaration is reference to a
25 1980 letter that appeared in the New England Journal

1 of Medicine?

2 A. Yes.

3 Q. That letter is commonly referred to as the
4 Porter and Jick letter?

5 A. Yes.

6 MR. BECKWORTH: I'm going to hand you,
7 sir, a copy of Exhibit 24.

8 (Portenoy Exhibit 24 was marked
9 for identification.)

10 MR. BECKWORTH: If you don't mind, take
11 a look at it. Please pass copies.

12 THE WITNESS: Thanks.

13 BY MR. BECKWORTH:

14 Q. What you're looking at is the Porter and
15 Jick letter; is that correct?

16 A. Yes.

17 Q. Now, in your declaration, you stated that
18 in the 2011 to '12 time frame, you had publicly
19 acknowledged that earlier work you had done left
20 behind evidence in an effort to destigmatize
21 opioids; is that a fair statement?

22 A. Yes. I regretted the use of those words:
23 "left behind evidence" because that was a mistake.
24 That was language that I shouldn't have used.
25 I didn't leave behind evidence.

1 But the evidence that I presented was --
2 did not sufficiently focus on risk, including the
3 risk of addiction, because in the early part of my
4 career, the risk of addiction was assumed. And the
5 problem was to some extent undertreatment, including
6 undertreatment of patients with cancer and acute
7 pain.

8 So although in my early work I presented
9 all of the epidemiology that then existed about the
10 risk of addiction, I didn't -- there was so little
11 data, and the data that did exist generally
12 supported the view that concerns about the risk of
13 addiction were overstated by physicians. And I did
14 not sufficiently in the early part of my career
15 focus on the risk elements.

16 As time went on and it became clear that
17 we had a public health problem in the United States
18 that was rapidly escalating related to overdose
19 abuse and addiction, I recalibrated my message. I
20 focused much more on teaching doctors how to assess
21 risk and how to manage risk; which we call risk
22 assessment and management as part of opioid therapy.

23 And that effort evolved as it became
24 clear that we had a problem in the United States
25 occurring because inexperienced prescribers were

1 prescribing drugs to the wrong patients and not
2 adequately monitoring them. And as a result of
3 that, we had, as you -- as you've alluded to, a very
4 large increase in things like overdose mortality.

5 Q. And to just go back through that answer,
6 one of the things you said was that, We had a public
7 health problem of rapidly escalating overdose,
8 abuse, and addiction, correct?

9 A. Yes.

10 Q. You also stated that it became clear that
11 we had a problem in the United States occurring
12 because inexperienced prescribers were prescribing
13 drugs to the wrong patients and not adequately
14 monitoring them, correct?

15 A. Yes.

16 Q. And because of that, we had a very large
17 increase in things like overdose mortality?

18 A. Yes.

19 MR. ERCOLE: Objection to form.

20 BY MR. BECKWORTH:

21 Q. All of the defendants that we've talked
22 about today targeted doctors with their sales force,
23 correct?

24 MR. ERCOLE: Objection to form.

25 THE WITNESS: Yes.

1 BY MR. BECKWORTH:

2 Q. Now, Porter and Jick, if you look at it,
3 is something that left evidence behind; would you
4 agree?

5 A. I wouldn't characterize it like that.
6 I would say that back in 1986 and the early part of
7 the 1990s, there was very, very little epidemiologic
8 data that related to the risk of addiction in
9 patients with pain who were given opioids.

10 The Porter and Jick article was one such
11 article. There was another article about patients
12 who were treated for burn pain, and the number there
13 was quite large, like 10,000 patients. But, again,
14 a very reassuring low rate of addiction. There was
15 another article about the rate of addiction in
16 patients receiving opioids for headache.

17 But we had no good epidemiology of the
18 type that has emerged in many papers between that
19 time and the present, which I alluded to before with
20 that article published last year, which looked at
21 12 papers that describe patients without any prior
22 history of abuse. None of that epidemiology
23 existed.

24 What I tried to do with my earliest
25 paper in '86 and then again in my reviews that I

1 wrote subsequently such as the one in '90 and '96,
2 is to describe all that epidemiology, indicate that
3 the epidemiology is problematic because it doesn't
4 really relate to the chronic treatment of patients,
5 but to say that the epidemiology that does exist
6 doesn't confirm the expectation that everybody who
7 gets an opioid is going to end up with an abuse
8 problem.

9 I think saying that at that time was
10 acceptable. But in retrospect, in hindsight, when I
11 look at the messages that I attached to those
12 epidemiologic papers, in the context of what
13 happened in the country in terms of the public
14 health problem, I'm sorry that I didn't know back
15 then what I got to know later because then I would
16 have messaged it in a different way.

17 I would have said, These papers are the
18 known epidemiology, but they carry so little
19 relevance to the long-term chronic treatment of
20 patients with chronic noncancer pain that you have
21 to extrapolate them very carefully, if at all.

22 Q. So let's stop there. These papers, like
23 Porter and Jick and the 10,000 cancer study, had so
24 little relevance to the long-term chronic treatment
25 of pain for noncancer people that you had to use

1 them very carefully, agreed?

2 A. Yes.

3 MR. ERCOLE: Objection to form.

4 BY MR. BECKWORTH:

5 Q. And so to use Porter and Jick, for example,
6 it had many limitations?

7 A. It did, yes.

8 MR. ERCOLE: Objection to form.

9 BY MR. BECKWORTH:

10 Q. It was about treatment of folks in a
11 hospital under the supervision of a doctor?

12 MR. ERCOLE: Same objection.

13 THE WITNESS: That's right.

14 BY MR. BECKWORTH:

15 Q. While in the hospital, correct?

16 A. Correct.

17 Q. It did not have an ability to provide
18 probability of future outcomes?

19 MR. ERCOLE: Objection to form.

20 THE WITNESS: That's correct.

21 BY MR. BECKWORTH:

22 Q. It lacked sophisticated statistical
23 analysis?

24 A. That's correct.

25 Q. It was published only as a letter?

1 A. That's correct.

2 Q. It was not peer reviewed?

3 A. I'm not sure that letters don't get peer
4 reviewed in that journal. That was the New England
5 Journal. But the limitations of the publication
6 were such that the editor made the decision it could
7 only be published as a letter.

8 Q. And it was not about rates of addiction for
9 people using opioids for chronic pain treatment long
10 term, was it?

11 A. It was not, right.

12 Q. So the question presented was actually:
13 What is the incidence of addiction after inpatient
14 exposure to an opioid in a hospital setting?

15 A. That's correct.

16 Q. That was it?

17 A. That was the question that they attempted
18 to answer.

19 Q. And you would agree that the management of
20 pain in a hospital setting under constant
21 supervision is quite different than a primary care
22 physician using opioids to treat noncancer chronic
23 pain out in the office?

24 A. Yes, that's true.

25 Q. So the findings in Porter and Jick were not

1 relevant to the question of what is the incidence of
2 addiction in a specific patient population during
3 opioid treatment that continues for months and years?

4 MR. ERCOLE: Objection to form.

5 THE WITNESS: That's true.

6 BY MR. BECKWORTH:

7 Q. And so if someone were to say, What's my
8 risk of getting addicted if I use opioids for
9 noncancer chronic pain treatment like lower back
10 pain, if someone were to hand me Porter and Jick and
11 say, You don't really have a risk at all or it's
12 less than 1 percent, that would be misleading?

13 MR. ERCOLE: Objection to form.

14 THE WITNESS: Yes, I think that would be
15 misleading.

16 BY MR. BECKWORTH:

17 Q. It would certainly be misleading for any
18 drug company to rely on Porter and Jick, as we sit
19 here today, as being high quality evidence supporting
20 a low risk factor for using opioids to treat
21 nonchronic -- I'm sorry -- noncancer chronic pain?

22 A. Yes, that's true.

23 MR. ERCOLE: Objection to form.

24 BY MR. BECKWORTH:

25 Q. If Janssen were to sit in testimony under

1 oath and say that Porter and Jick supports the
2 notion that using opioids for noncancer chronic pain
3 is safe and effective and rely on Porter and Jick,
4 that would be wrong?

5 MR. ERCOLE: Objection to form.

6 THE WITNESS: That would be wrong, yes.

7 BY MR. BECKWORTH:

8 Q. Excuse me. I was objected to. Your answer
9 was?

10 A. That would be wrong, yes.

11 Q. It's also -- based on your personal
12 knowledge and understanding, is it also misleading
13 to refer to Porter and Jick as supporting the idea
14 that there is a less than one percent risk of
15 addiction when taking opioids for noncancer chronic
16 pain therapy?

17 A. Yes, that's -- I want to make sure that I
18 heard your question correctly and I answer it.

19 Q. Let me ask it again.

20 A. Please, yeah.

21 Q. Based upon your personal knowledge and
22 understanding --

23 A. Um-hum.

24 Q. -- can you state whether or not it's
25 misleading to refer to Porter and Jick as supporting

1 the idea that there is a less than one percent risk
2 of addiction when taking opioids for noncancer
3 chronic pain therapy without disclosing the
4 limitations of that letter?

5 MR. ERCOLE: Objection to form.

6 THE WITNESS: Yes, I agree with that.

7 BY MR. BECKWORTH:

8 Q. Yes, it would be misleading?

9 A. It would be misleading.

10 Q. Let's turn real quickly to paragraph what I
11 believe is 46 of your declaration. Now, we
12 discussed this a little bit earlier, but let's go
13 back over this.

14 Based on your professional experience
15 and background, do you have an opinion as to whether
16 direct-to-patient marketing should be done by a drug
17 company that makes themselves opioids?

18 A. Yes, I have an opinion about that.

19 Q. What is it?

20 A. That it should not be done.

21 Q. At one point you stated that you advised
22 Janssen against a direct-to-consumer campaign,
23 correct?

24 A. That's true. Yes.

25 Q. Now, you stated that with respect to that

1 one idea, it wasn't done?

2 A. Yes.

3 Q. Are you aware that Janssen actually engaged
4 in a direct-to-patient marketing campaign that was
5 centered upon elder folks?

6 MR. EHSAN: Objection to form.

7 THE WITNESS: No, I'm not aware of that.

8 BY MR. BECKWORTH:

9 Q. Would it be wrong for a drug company to go
10 directly to a specific subset of the population,
11 including the elderly, to market the use of opioids
12 for chronic noncancer pain?

13 MR. ERCOLE: Objection to form.

14 THE WITNESS: Yes. I don't think that
15 that should be done.

16 BY MR. BECKWORTH:

17 Q. And the reason is why?

18 A. Patients don't have the knowledge to make a
19 judgment about what the risks are of that treatment.
20 And if marketing is done that suggests to them that
21 pain relief is a possibility, they're going to focus
22 on that. And they're going to bring that information
23 to their physicians, and they're going to ask for
24 these drugs, or to push their physicians to
25 prescribe these drugs.

1 And then they just have to be hopeful
2 that their physicians have been adequately educated
3 and have the ability to say no to a patient who
4 perhaps assertively or plaintively says: Treat me,
5 I have terrible pain. And I think it just increases
6 the risk that inappropriate patients are going to
7 get access to opioids and may suffer consequences,
8 negative consequence as a result of that.

9 Q. Well, the relationship between a patient
10 and her doctor should be a private one, correct?

11 A. Yes.

12 Q. And there should not be interference by
13 outside forces, correct?

14 A. Yes.

15 Q. So if a company that sells a drug markets
16 directly to that patient and teaches that patient
17 how to ask for specific things, that interferes with
18 the direct relationship between the patient and the
19 doctor, correct?

20 MR. ERCOLE: Objection to form.

21 THE WITNESS: It can. You know,
22 obviously we live in an era where direct-to-consumer
23 advertising is happening for all kinds of drugs.
24 And I think there's always a risk that when that's
25 done, you encourage patients who lack information

1 about safety and effectiveness to have a conversation
2 with a physician who may feel under pressure to
3 prescribe or to prescribe a specific drug.

4 With respect to the opioids, the risk
5 profile is serious enough, particularly with what
6 emerged as a health concern over the course of time,
7 that I think that's a really terrible idea: to do
8 direct-to-consumer advertising for opioids.

9 BY MR. BECKWORTH:

10 Q. And you came back to answer this. But you
11 said that direct-to-consumer advertising happens for
12 all kinds of drugs. That's not actually 100 percent
13 correct, is it? We don't have direct-to-consumer
14 advertising for Schedule II narcotics?

15 MR. ERCOLE: Objection to form.

16 THE WITNESS: What you're saying is
17 true.

18 BY MR. BECKWORTH:

19 Q. So whether you like to or not, it's quite a
20 different thing to go on a TV commercial about
21 something like Cialis than it is for something like
22 OxyContin, correct?

23 A. I think it is, yes.

24 Q. Or Duragesic?

25 A. Yes.

1 Q. Or Nucynta?

2 A. Yes.

3 Q. Or any opioid that any of these companies
4 make?

5 MR. ERCOLE: Objection to form.

6 THE WITNESS: Yes.

7 BY MR. BECKWORTH:

8 Q. Correct?

9 A. I believe that's true, yes.

10 Q. And when a drug company goes directly to a
11 subset of a patient population and markets directly
12 to that group, that's crossing the line?

13 MR. ERCOLE: Objection to form.

14 THE WITNESS: In my opinion, with
15 respect to the opioids, the Schedule II opioids --
16 with respect to any opioid, I think the risks of
17 adverse consequences, not just abuse and addiction,
18 but also adverse consequences like falls and
19 cognitive change, particularly in the elderly, are
20 too grave to justify a direct-to-consumer campaign.

21 The risks of a drug like Cialis don't
22 match up to the risk of drugs that are Schedule II
23 opioids. And I think it is true that whether you
24 like direct-to-consumer advertising or not as a
25 general concept, in my opinion, direct-to-consumer

1 advertising for opioids is a mistake.

2 BY MR. BECKWORTH:

3 Q. Especially in the unbranded area?

4 MR. ERCOLE: Objection to form.

5 MR. EHSAN: Objection to form.

6 THE WITNESS: I'm not sure. Explain to
7 me what that question is. I'm not sure.

8 BY MR. BECKWORTH:

9 Q. Well, it would be one thing if you went to
10 a subset and directly marketed to them and said, Use
11 our product: Fentora, Duragesic, OxyContin. That's
12 branded direct marketing.

13 Do you understand that?

14 A. Yes.

15 MR. ERCOLE: Objection to form.

16 BY MR. BECKWORTH:

17 Q. But when you go to specific patient
18 populations and just talk about opioids generally
19 and say things like: You should ask your doctor for
20 opioids; don't be scared of them; they're not
21 addictive, that's potentially even more dangerous?

22 MR. ERCOLE: Objection to form.

23 THE WITNESS: I'm not sure I would parse
24 it that way. I don't like either concept, to be
25 honest with you, whether it's branded or unbranded.

1 I don't think that direct-to-consumer advertising
2 for opioids is the right thing to do.

3 BY MR. BECKWORTH:

4 Q. Both are bad?

5 A. Both are bad in my opinion.

6 Q. And you made the remark about how this can
7 interfere with the patient and doctor relationship.

8 Do you remember that?

9 A. Yes.

10 Q. But it also causes a problem with people
11 who might have illicit desires, doesn't it?

12 A. Yes.

13 Q. Because if someone is truly an unlawful
14 drug user, it teaches her how to go in and tell a
15 doctor the right buzzwords to get prescribed?

16 MR. ERCOLE: Objection to form.

17 THE WITNESS: Yes. I think that's a
18 component of why it's a bad thing. The risk of
19 addiction is there. And the risk of addiction
20 developing is much higher in patients who have the
21 disease of addiction.

22 The most important predisposing factor
23 to develop addiction is a prior history of substance
24 abuse. So patients who have a prior history of
25 substance abuse and particularly a prior history of

1 addiction, using information they gain from direct-
2 to-consumer advertising to communicate with a
3 physician just is part of the problems that I'm
4 concerned about.

5 BY MR. BECKWORTH:

6 Q. It's never good?

7 MR. ERCOLE: Objection to form.

8 THE WITNESS: In my opinion, direct-to-
9 consumer advertising is not good.

10 BY MR. BECKWORTH:

11 Q. It was wrong to do it?

12 A. Yes.

13 MR. ERCOLE: Objection to form.

14 BY MR. BECKWORTH:

15 Q. Yes, it was wrong to do it?

16 A. Yes, in my opinion.

17 MR. BECKWORTH: I want to hand you what
18 we'll mark as Exhibit 30 [sic].

19 (Discussion off the record.)

20 MR. BECKWORTH: 25, yes. My apologies.

21 (Portenoy Exhibit 25 was marked
22 for identification.)

23 BY MR. BECKWORTH:

24 Q. Sir, this is a long document. You're
25 welcome to read it all, but I'm going to direct your

1 attention to one thing after you look at it.

2 MS. SPENCER: Give him a chance just to
3 digest it.

4 MR. BECKWORTH: I will. I'm just going
5 to read something for the record while he's doing
6 that. Exhibit 25 is PPLP004281019. It is entitled
7 "Purdue Pharma, L.P. Corporate Reputation and
8 Visibility Strategic Plan, updated as of January 21,
9 2011."

10 BY MR. BECKWORTH:

11 Q. Sir, please look through that at your
12 convenience. I'm going to turn your attention to
13 page 25 as the document itself is numbered.

14 A. Okay.

15 Q. So there's a lot in this document. You're
16 free to look at it all, but I want to focus your
17 attention to page 25 for just a second.

18 Do you remember earlier in the day we
19 were talking about how Janssen had an internal
20 document that they would use speakers as part of the
21 sales effort to sell one of their drugs.

22 Do you remember that?

23 A. Yes.

24 Q. So here you see in this document on page 25
25 a section called "Maximizing external relationships,

1 create/build new ones"? Do you see that?

2 A. Yes, I do.

3 Q. It says "Key opinion leaders and
4 professional associations can support or interfere
5 with the company's efforts to reach key audiences."

6 Do you see that?

7 A. Yes.

8 Q. And it says "KOLs can influence health care
9 professionals' prescribing practices."

10 Do you see that?

11 A. Yes.

12 Q. Now, you know that you were viewed as a key
13 opinion leader by Purdue, correct?

14 A. Yes.

15 Q. Did you know that internally Purdue took
16 the belief that KOLs that it utilized could
17 influence health care professionals' prescribing
18 practices?

19 A. I was never informed of a strategic plan
20 that included that, no.

21 Q. Did you ever know or believe that Purdue
22 would use you as part of a corporate effort to
23 influence health care professionals' prescribing
24 practices?

25 A. The way that I would respond to that is

1 that I understood the relationship with Purdue and
2 other pharma companies to be one in which they would
3 use my expertise to expand educational opportunities.

4 And if you're asking me, was I aware
5 that there was a vision to use KOLs like myself in
6 marketing strategies, I wasn't aware of that, no.

7 Q. And that's wrong to do?

8 MR. ERCOLE: Objection to form.

9 THE WITNESS: I believe it is wrong to
10 do.

11 BY MR. BECKWORTH:

12 Q. A company that sells a drug cannot and
13 should not use a KOL or speaker for the intended
14 purpose of selling more of that company's drugs,
15 right?

16 MR. ERCOLE: Objection to form.

17 THE WITNESS: Right.

18 BY MR. BECKWORTH:

19 Q. If they do that, then anything that that
20 person does, it needs to be disclosed to the
21 audience that that person is there speaking with the
22 stated objective of influencing his or her
23 audience's prescribing practices, correct?

24 MR. ERCOLE: Objection to form.

25 THE WITNESS: Right. Again, I would say

1 it's a little bit more complicated, in my view,
2 because the purpose of a KOL engaging in professional
3 education was to -- in my view, it was to create a
4 comfort level on the part of physicians to use this
5 tool appropriately to try to help patients with
6 chronic pain. To the extent that clinicians gained
7 skills, they might use the drug more.

8 So I had no problem with the concept
9 that my efforts to educate would lead to more
10 prescribing because I assumed, if you will, that it
11 would be an epiphenomenon. In other words, the
12 phenomenon that I was trying to accomplish was
13 education to try to reduce the stigma attached to
14 these drugs and educate physicians about how to use
15 them.

16 The epiphenomenon is if you feel more
17 comfortable using these drugs, you know what
18 patients to select, you know how to monitor the
19 patients, you're going to use more than you did in
20 the past. And that would be okay, as long as the
21 patients were the appropriate patients who were
22 being treated in the appropriate way.

23 To the extent that those steps are not
24 articulated by the company and to the extent that
25 the primary aim is for the KOLs to be sort of

1 engaged in changing prescribing behavior for the
2 purpose of increasing prescription on the part of
3 the doctors, that makes me uncomfortable. That
4 wasn't the role of any of the KOLs.

5 BY MR. BECKWORTH:

6 Q. As you understood it?

7 A. As I understood it, correct.

8 Q. But it was the role as, in this instance,
9 Purdue understood it?

10 MR. ERCOLE: Objection to form.

11 THE WITNESS: That's what this document
12 seems to imply, yes.

13 BY MR. BECKWORTH:

14 Q. Purdue never came to you and said: You're
15 part of our advocacy team?

16 A. No. No, no.

17 Q. We want you to influence legislators and
18 doctors and patients? They never told you that?

19 A. No, no.

20 Q. They never told you that you were part of a
21 marketing plan to sell more drugs?

22 A. No.

23 Q. Janssen never told you that?

24 A. That's correct.

25 Q. Cephalon never told you that --

1 MR. ERCOLE: Objection to the form.

2 THE WITNESS: That's correct.

3 BY MR. BECKWORTH:

4 Q. -- did it?

5 A. No. That's correct.

6 MR. BECKWORTH: Now, we'll look at a
7 couple more examples of this. Remember earlier we
8 talked about Janssen. I'm going to hand you what
9 we'll mark as Exhibit 26.

10 (Portenoy Exhibit 26 was marked
11 for identification.)

12 BY MR. BECKWORTH:

13 Q. Take a moment to take a look at this
14 document, if you don't mind.

15 Ready?

16 A. Yes.

17 Q. So, sir, this is an internal document about
18 Duragesic, do you see that?

19 A. Yes.

20 Q. Here at the top it says "Congratulations to
21 the 275 Sales Force. With your leadership,
22 Duragesic attained numerous all-time highs in
23 prescriptions and dollar volumes in 2000," correct?

24 A. Yes.

25 Q. Now, it talks about sales efforts there in

1 bold. Do you see that?

2 A. Yes.

3 Q. And it says, "Thanks to you, 2001 promises
4 to be an exciting time for Duragesic. We will
5 surpass half a billion dollars in sales."

6 Do you see that?

7 A. Yes.

8 Q. And it goes on to talk about the market
9 update.

10 MS. SPENCER: I don't think I got one of
11 those.

12 THE WITNESS: Oh.

13 MS. SPENCER: Thank you. Sorry.

14 BY MR. BECKWORTH:

15 Q. There's a belief that Duragesic will exceed
16 half a billion dollars in 2001. Do you see that?

17 A. Yes.

18 Q. Now, down below it says, "Strategic focus."
19 And the first thing listed is "High deciled
20 physicians," correct?

21 A. Yes.

22 Q. And it says, "The high deciled physicians
23 continue to represent significant opportunity for
24 Duragesic due to their high volume prescribing of
25 chronic pain medications and the disparity in share

1 between OxyContin and Duragesic."

2 Do you see that?

3 A. Yes.

4 Q. It goes on to say that, "Even though our
5 deciling methods has changed, the same 8,000
6 physicians that we focused on in 2000 are still
7 those we will concentrate on in 2001."

8 Do you see that part?

9 A. Yes.

10 Q. And it also says, "with even greater
11 emphasis being placed on the top 1,000 who account
12 for 20 percent of all the dollars in the pain
13 market."

14 Do you see that?

15 A. Yes.

16 Q. That's a very tight focus on a subset of
17 prescribers who the authors of this document believe
18 represent 20 percent of the overall pain market?

19 A. Yes.

20 Q. Do you see that?

21 A. Yes.

22 Q. That's a high level of precision; would you
23 agree?

24 A. Yes.

25 Q. Now, if you go down to the third bullet

1 there, it says, "Expand Duragesic use in
2 nonmalignant pain," correct?

3 A. Yes.

4 Q. And it says -- this is what we've talked
5 about all day -- "Physicians are becoming more
6 comfortable in using opioids in nonmalignant pain"?

7 A. That's correct, right.

8 Q. "Our objective is to" --

9 I'm just going to have you read the next
10 sentence for the jury. What does the next sentence
11 say?

12 A. "Our objective is to convince them that
13 Duragesic is effective and safe to use in areas such
14 as chronic back pain, degenerative joint disease,
15 and osteoarthritis."

16 Q. Now, there's that word again: "convince,"
17 right? And they're referring to who?

18 A. To probably primary care doctors mostly.

19 Q. About chronic back pain, osteoarthritis,
20 and degenerative joint disease, right?

21 A. Right.

22 Q. Those are areas that we have never used
23 opioids long term to treat prior to 1996?

24 A. Very uncommonly did, prior to that.

25 Q. And here at the bottom -- now, you were the

1 president of the American Pain Society, correct.

2 A. Yes.

3 Q. And if I remember, your presidency occurred
4 in the 2001 time frame?

5 A. I think so.

6 Q. What does the next sentence say?

7 A. "It is important to remind physicians that
8 APS, AAPM, and AGS have all endorsed the appropriate
9 use of opioids to manage chronic nonmalignant pain."

10 Q. Now, that's a true statement. You did do
11 that, right?

12 A. That's right.

13 Q. You had no idea though, when you were
14 receiving funding from these companies that your
15 endorsement would be used by the sales force to
16 target doctors?

17 MR. EHSAN: Object to form.

18 THE WITNESS: That's correct.

19 BY MR. BECKWORTH:

20 Q. You had no idea?

21 A. Right. We did not.

22 Q. How does that make you feel to see this
23 today?

24 A. As I said before, and particularly as the
25 years moved forward -- this was in -- early in the

1 2000s. And as the 2000s became 2010 and then beyond
2 that, as the concern about the public health problem
3 became more and more prominent, the idea that any of
4 the documents that were being created for education
5 were also being used for marketing without
6 appropriate caveats and statements of risk would
7 make me very uncomfortable.

8 MS. SPENCER: If I may just for the
9 record, he was president from 1998 to 1999, not 2001.

10 MR. BECKWORTH: Thank you.

11 THE WITNESS: Thank you.

12 BY MR. BECKWORTH:

13 Q. So to correct that, this occurred after
14 your presidency?

15 A. Yes.

16 Q. But while you were still active in APS?

17 A. I was still active in it, yes.

18 Q. And to use -- you would agree that APS was
19 influential, correct?

20 A. Mostly among pain specialists, not among
21 the rest of the medical community.

22 Q. Well, we have the consensus statement that
23 went out?

24 A. Yes.

25 Q. That was sent out broadly?

1 A. That's true.

2 Q. And now we have this defendant telling its
3 sales force to refer to the APS in order to help it
4 sell more drugs, right?

5 A. Yes.

6 Q. And it's not just to anybody? It's to a
7 very tightly defined group that represents 20 percent
8 of the prescribing market for that drug?

9 MR. EHSAN: Objection to form.

10 THE WITNESS: Yes. I'm reading this a
11 little bit differently than that. The high deciled
12 physicians was one category of physicians who were
13 the focus of the marketing. And the broader group
14 of physicians who were treating most of the
15 noncancer pain, like most of the osteoarthritis, was
16 another category of physicians that were part of the
17 marketing -- were viewed as marketing opportunities.

18 BY MR. BECKWORTH:

19 Q. And they're targeting right to them?

20 MR. EHSAN: Objection to form.

21 THE WITNESS: Yes. Well, they're
22 targeting both groups.

23 BY MR. BECKWORTH:

24 Q. And using a group that's supposed to be
25 independent as part of that step?

1 MR. ERCOLE: Objection to form.

2 THE WITNESS: I would say using
3 something produced by that group and endorsed by the
4 board of that group and other professional societies
5 as well, and using that educational tool for
6 marketing purposes is improper.

7 BY MR. BECKWORTH:

8 Q. It's something you didn't know about?

9 A. Right.

10 Q. And it's something they didn't tell you
11 about, correct?

12 A. Right. Correct.

13 Q. And it's wrong to do?

14 A. Right.

15 MR. EHSAN: Object to form.

16 MR. BECKWORTH: I'm going to hand you,
17 sir, what we'll mark as Exhibit 27.

18 (Portenoy Exhibit 27 was marked
19 for identification.)

20 MR. COLEMAN: Can we get a time check?
21 Three hours and 40 minutes; is that what you're
22 saying?

23 THE VIDEO OPERATOR: Yes.

24 MR. COLEMAN: Thank you.

25

1 BY MR. BECKWORTH:

2 Q. Now, sir, you've had a chance to look at
3 this document, which is Exhibit 27, correct?

4 A. Yes.

5 Q. And that document is a Janssen document
6 dated November 6, 2003, again about Duragesic,
7 correct?

8 A. Yes.

9 Q. And I know you just got it, but in the
10 situation analysis, what's happening is there's
11 concern that there is a generic version of Duragesic
12 that's going to hit the market, correct?

13 A. Yes.

14 Q. That will be a competitive product, correct?

15 A. Yes.

16 Q. And the generic patches, it says, will
17 likely be in a matrix formulation in which the
18 fentanyl is contained within an adhesive layer
19 rather than a reservoir; do you see that?

20 A. Yes.

21 Q. If you look down at the conclusions, it
22 says, "Duragesic and the matrix patch are seen as
23 essentially the same product" --

24 A. Yes.

25 Q. -- correct?

1 A. Um-hum.

2 Q. "Exposure to the product profile and
3 potential counter-detailing messages regarding the
4 matrix patch will likely" -- "will not likely impact
5 physician prescribing."

6 And it goes into multiple reasons for
7 that, correct?

8 A. Yes.

9 MR. EHSAN: Objection to form.

10 BY MR. BECKWORTH:

11 Q. So if you look here to "Recommendations,"
12 the first recommendation said to "Explore ways to
13 involve unbiased third parties." It lists "(FDA,
14 DEA, and advocacy groups) in educating the market
15 about the potential pitfalls of the matrix patch.
16 Having Janssen sales representative deliver such a
17 message will likely have little impact and may
18 damage the credibility of both the message and the
19 representative."

20 Do you see that?

21 A. Yes.

22 Q. Did you ever know that Janssen looked at
23 third-party advocacy groups that way?

24 A. No.

25 MR. EHSAN: Objection to form.

1 BY MR. BECKWORTH:

2 Q. So what we have here -- you can see it for
3 yourself --

4 A. Right.

5 Q. -- we've got the sales side of Janssen
6 looking at ways to squash a new competitive generic
7 product, right?

8 MR. EHSAN: Objection to form. And
9 counsel, this doesn't have any Bates stamps on it.
10 Was this document produced? If so --

11 MR. BECKWORTH: Some of these were
12 produced in native form. We can get you a Bates
13 stamp.

14 BY MR. BECKWORTH:

15 Q. You understand that they're trying to
16 squash a competitive product?

17 A. Yes.

18 MR. EHSAN: Object to form.

19 BY MR. BECKWORTH:

20 Q. And it says that their sales force may not
21 have a credible message because they're tied to
22 Janssen?

23 A. Yes.

24 Q. And so who are they trying to leverage to
25 help deliver their sales message?

1 MR. EHSAN: Object to form.

2 THE WITNESS: Independent third parties.

3 BY MR. BECKWORTH:

4 Q. Including advocacy groups?

5 A. Yes.

6 Q. Which you were part of?

7 A. Yes.

8 Q. But it's not just them? It's the federal
9 government --

10 A. Yes.

11 Q. -- right?

12 How does that make you feel?

13 MR. EHSAN: Object to form.

14 THE WITNESS: Yeah. I think to the
15 extent that that -- this idea became policy and was
16 implemented, it would make me uncomfortable.

17 BY MR. BECKWORTH:

18 Q. Now, you are familiar with the product
19 called Fentora, correct?

20 A. Yes.

21 Q. What do you understand Fentora to be?

22 A. Fentora is one of the transmucosal
23 immediate release formulations of fentanyl, and it's
24 approved for the management of cancer-related
25 breakthrough pain.

1 Q. Cancer-related breakthrough pain?

2 A. Yes.

3 MR. BECKWORTH: I'm going to hand you
4 this.

5 (Portenoy Exhibit 28 was marked
6 for identification.)

7 BY MR. BECKWORTH:

8 Q. And who makes Fentora?

9 A. I think --

10 MS. SPENCER: This is 28?

11 MR. BECKWORTH: I believe so.

12 THE WITNESS: Fentora was made by
13 Cephalon.

14 BY MR. BECKWORTH:

15 Q. Now, this is kind of a long document.
16 While you're looking through it, the title of this
17 is "Commercialization team update, Fentora,
18 October 25, 2006."

19 (Discussion off the record.)

20 THE WITNESS: Okay.

21 BY MR. BECKWORTH:

22 Q. So if you look in about six pages, you'll
23 see one called "Publications update, abstracts
24 submitted September '06"?

25 A. Yes.

1 Q. And Study 3042, "low back pain," is
2 something that's cited, correct?

3 A. Yes.

4 Q. And one of the authors of that is you?

5 A. Yes.

6 Q. And it says, "Congress: AAPM."

7 What do you understand AAPM to be?

8 MR. ERCOLE: Objection to form.

9 THE WITNESS: American Academy of Pain
10 Medicine.

11 BY MR. BECKWORTH:

12 Q. Have you ever seen this document before?

13 A. No.

14 Q. Now, as you flip through it, you'll see --
15 I'm not going to ask you on these because it's not
16 your work -- but you'll see there's lots of
17 forecasts about total prescriptions of Fentora.

18 Do you see that?

19 A. Yes.

20 Q. If you'll go a little further in, you'll
21 see a section that says, "Functional area updates"?

22 A. Yes.

23 Q. If you flip to the next page, there's one
24 that says "Marketing update, launch materials."

25 Do you see that?

1 A. Yes.

2 MS. SPENCER: It's a chart?

3 MR. BECKWORTH: Yes, ma'am.

4 BY MR. BECKWORTH:

5 Q. And it says "4Q06"? Do you see that?

6 A. Yes.

7 Q. And there's quite a bit here from the sales
8 force and there's all kinds of different tear sheets
9 or flash cards and other things in there about a
10 sales force.

11 Do you see that?

12 MR. ERCOLE: Objection to form.

13 THE WITNESS: Yes, I do.

14 BY MR. BECKWORTH:

15 Q. Do you see it?

16 And on the top left corner, it says
17 "Shipment 1 (10/2)."

18 Do you see that?

19 A. Yes.

20 Q. And it's all kinds of things: "RiskMAP
21 flashcard, voucher books, CSP invitations,
22 medication guide."

23 Do you see that?

24 A. Yes.

25 Q. But there's one more listed?

1 A. Right.

2 Q. What's under that?

3 A. "Taylor/Portenoy abstract."

4 Q. Your document?

5 A. Right. The abstract of my study.

6 Q. Did you know that your documents were being
7 used by the sales force of Cephalon to sell and
8 launch products?

9 MR. ERCOLE: Objection to form.

10 THE WITNESS: No, I didn't know that.

11 BY MR. BECKWORTH:

12 Q. Did they ever tell you that?

13 A. No.

14 Q. When they paid you money to do work and
15 consulting work for them or be a speaker, that was
16 supposed to be unbranded, right?

17 MR. ERCOLE: Objection to form.

18 THE WITNESS: Yes.

19 BY MR. BECKWORTH:

20 Q. You weren't there to market their specific
21 drugs?

22 MR. ERCOLE: Same objection.

23 THE WITNESS: Right.

24 BY MR. BECKWORTH:

25 Q. You were there to educate?

1 A. Just to clarify. This was a study. This
2 was an IRB, an institutional review board protocol-
3 directed study that yielded data about efficacy.

4 Q. That is being used by their sales force,
5 correct?

6 A. That's correct.

7 Q. Right along with flash cards and other
8 marketing materials?

9 A. That's correct.

10 MR. ERCOLE: Objection to form.

11 BY MR. BECKWORTH:

12 Q. And you didn't know that?

13 A. No.

14 MR. ERCOLE: Same objection.

15 BY MR. BECKWORTH:

16 Q. If you go to the next page, there's a
17 "Marketing update" with "Key activities."

18 Do you see that?

19 MS. SPENCER: That's two pages later.

20 MR. BECKWORTH: Two pages, yes.

21 THE WITNESS: Yes.

22 BY MR. BECKWORTH:

23 Q. And if you'll flip just a few more, you'll
24 come to one -- it will be on your left-hand side --
25 called "PR update."

1 Do you see that?

2 A. Yes.

3 Q. And under the "PR update," it talks about
4 PR, and there's quite a few things listed, correct?

5 A. Yes.

6 Q. And one of them is "BTP and Fentora
7 highlighted in third-party group materials."

8 Do you see that?

9 A. Yes.

10 Q. And there at the bottom it says "American
11 Pain Foundation," correct?

12 A. Yes.

13 Q. "Printed 'Treatment options: A guide for
14 people living with pain.'" And then -- that was the
15 title of it. And then it goes on to say
16 "information on BTP and Fentora," correct?

17 A. Yes.

18 Q. Sir, when you were doing this work, nobody
19 told you that work that you were doing for research
20 and education was also being leveraged by the sales
21 team at Cephalon, true?

22 MR. ERCOLE: Objection to form.

23 THE WITNESS: That's true.

24 BY MR. BECKWORTH:

25 Q. Never told you that?

1 MR. ERCOLE: Same objection.

2 THE WITNESS: That's true.

3 BY MR. BECKWORTH:

4 Q. Would you have liked to know?

5 MR. ERCOLE: Same objection.

6 THE WITNESS: Yes. I think it would
7 have been very important to know that that was the
8 intent, that was the plan because that -- to the
9 extent that research or educational programming was
10 used for marketing, I would have tried to stop that
11 or I would have tried to modify it in a way so that
12 it wasn't used for marketing; it was used for
13 education or for publication purposes.

14 BY MR. BECKWORTH:

15 Q. But to stop something from being done that
16 you disagree with, you got to know that it's
17 happening?

18 MR. ERCOLE: Same objection.

19 THE WITNESS: Right.

20 BY MR. BECKWORTH:

21 Q. And these folks engaged in all kinds of
22 different funding opportunities with you and your
23 employer, correct?

24 A. Yes.

25 MR. EHSAN: Objection.

1 BY MR. BECKWORTH:

2 Q. And the boards you worked on?

3 A. Um-hum.

4 Q. "Yes"?

5 A. Yes.

6 Q. But all the things we've gone over about
7 how this was being used internally, they didn't tell
8 you that, did they?

9 A. No.

10 MR. ERCOLE: Objection to form.

11 BY MR. BECKWORTH:

12 Q. Did they?

13 A. No. We had no information about how the
14 marketing teams were going to use different
15 protected information.

16 MR. BECKWORTH: I'm going to hand you --
17 we're just about done -- Exhibit 29.

18 (Portenoy Exhibit 29 was marked
19 for identification.)

20 BY MR. BECKWORTH:

21 Q. There are two documents that we've pulled.
22 The first one I'll represent is from the CDC and the
23 second one is sourced on the bottom.

24 You've probably seen quite a few charts
25 like this in your day?

1 A. Yes.

2 Q. So on the first one here on Exhibit 29,
3 it's titled [as read], Rates of opioid sales,
4 overdose -- or OD -- deaths, and treatment from 1999
5 to 2010, correct?

6 A. Yes.

7 Q. And we see on the left-hand corner,
8 whatever the rate that's being depicted in 1999,
9 it's low; would you agree?

10 A. Yes.

11 Q. On this chart. And as we get to 2010,
12 things go up, don't they?

13 A. Yes.

14 Q. We have a green line that represents opioid
15 sales in kilograms per 10,000. That green line from
16 '99 to 2010 goes up considerably, correct?

17 MR. EHSAN: Objection to form.

18 THE WITNESS: Yes.

19 BY MR. BECKWORTH:

20 Q. Opioid deaths -- I believe that's red, to
21 my eyes -- per 100,000 goes up considerably during
22 this time period, correct?

23 A. Yes.

24 MR. ERCOLE: Objection to form.

25

1 BY MR. BECKWORTH:

2 Q. And opioid treatment admissions per 10,000,
3 which I believe is a blue line, goes up considerably
4 during this period of time, correct?

5 A. Yes.

6 MR. ERCOLE: Objection to form.

7 BY MR. BECKWORTH:

8 Q. Now, if you'll turn to the next page, we
9 talked about how when you wrote your '96 paper,
10 there were a lot of fears out about using opioids to
11 prescribe for -- to treat noncancer chronic pain,
12 correct?

13 A. Yes.

14 Q. And we also know that about the same time
15 you wrote that paper in December of 1995, Purdue
16 took OxyContin to market, correct?

17 A. Yes.

18 Q. And we know that oxycodone is the active
19 pharmaceutical ingredient in OxyContin, correct?

20 A. Yes.

21 Q. And I showed you an exhibit from Janssen
22 where Janssen had given -- or Johnson & Johnson had
23 given the Johnson Medal to a scientist for creating
24 the Norman poppy strand of thebaine, correct?

25 MR. EHSAN: Objection to form.

1 THE WITNESS: Yes.

2 BY MR. BECKWORTH:

3 Q. And in that document, they gave that medal
4 and it said the creation of that strand of poppy was
5 transformational and it led to the growth of
6 oxycodone. You saw it with your own eyes, right?

7 MR. EHSAN: Objection to form.

8 MR. ERCOLE: Objection to form.

9 THE WITNESS: Yes.

10 BY MR. BECKWORTH:

11 Q. The supplier of oxycodone to Purdue, one of
12 them, was Noramco, a company that is a subsidiary of
13 Johnson & Johnson. You learned that today, didn't
14 you?

15 MR. EHSAN: Objection.

16 MR. ERCOLE: Objection to form.

17 BY MR. BECKWORTH:

18 Q. Now, let's look here at this chart. The
19 line from 1980 to 1996 for oxycodone consumption
20 measured in milligrams per capita was virtually
21 flat, correct?

22 A. Yes.

23 Q. And then something happened around 1996,
24 right?

25 A. Yes.

1 Q. Did it go up or down?

2 A. It went up.

3 Q. Did it go up sharply?

4 A. Yes.

5 Q. And it stayed up for a long time, correct?

6 A. Yes.

7 Q. And then sometime after 2012, consumption
8 went down, but it still is markedly higher than it
9 was in '96, correct?

10 A. Correct.

11 Q. Now, all that's reflected in what appears
12 to me to be a blue line for USA oxycodone; do you
13 see that?

14 A. Yes.

15 MR. ERCOLE: Objection to form.

16 BY MR. BECKWORTH:

17 Q. There's another line under it in red,
18 correct?

19 A. Yes.

20 Q. What does that represent?

21 A. That represents oxycodone consumption in
22 Europe.

23 Q. And what's happened there?

24 A. It's basically been flat during this time
25 frame.

1 Q. Now, you said earlier -- and I'm going to
2 try to find your exact words -- that we had a public
3 health problem rapidly escalating: overdose, abuse,
4 and addiction in this country that you became aware
5 of, correct?

6 A. Yes.

7 MR. ERCOLE: Objection to form.

8 BY MR. BECKWORTH:

9 Q. And when you look at the second page of
10 this exhibit, would you agree with me, sir, that
11 oxycodone consumption measured in milligrams per
12 capita in the United States rapidly escalated after
13 1996? Is that a fair statement?

14 A. Yes.

15 Q. Now, we've been here for a long time, sir.
16 This started out talking about how you've been sued
17 by some different government agencies in various
18 litigation around the country, correct?

19 A. Yes.

20 Q. And I told you that we have no intent to
21 sue you, correct?

22 A. Yes.

23 Q. But you know that there are folks out there
24 who have blamed you for having some part in creating
25 this public health problem that we have in the

1 United States? You're aware of that?

2 A. Yes.

3 MR. ERCOLE: Objection to form.

4 BY MR. BECKWORTH:

5 Q. Now, this is your opportunity -- and I'm
6 going to tell you something -- we deposed, put under
7 oath a corporate representative of Janssen and
8 Purdue, Cephalon/Teva, all of them. We put them
9 under oath. They're going to answer to this jury.
10 Their drug company lawyers are here.

11 Every single time we've asked them:
12 Do you share even 0.1 percent responsibility for
13 causing the public health problem we have in this
14 country in the State of Oklahoma, do you know what
15 they've said?

16 MR. ERCOLE: Objection.

17 THE WITNESS: No.

18 BY MR. BECKWORTH:

19 Q. Without fail, do you know what they've
20 said?

21 MR. ERCOLE: Same objection.

22 THE WITNESS: No.

23 BY MR. BECKWORTH:

24 Q. I'll represent to you they have all said
25 no. Just yesterday the head of Teva's generic

1 production in the United States of America, which
2 includes the very same OxyContin they produce?

3 Do you know what she said? 0 percent.

4 MR. ERCOLE: Objection to form.

5 BY MR. BECKWORTH:

6 Q. I deposed a Purdue Corp representative on
7 Tuesday. Do you know what he told me?

8 A. No.

9 Q. 0 percent. So you can choose to believe
10 me. I can go get the testimony and show it to you.
11 Take all that aside for a moment. Can one man
12 create an opioid crisis in the country by himself?

13 MR. ERCOLE: Objection to form.

14 THE WITNESS: Yeah. I don't think so.
15 It's not possible.

16 BY MR. BECKWORTH:

17 Q. To the extent we have a public health
18 problem in this country, do you think it's right for
19 Purdue to say they bore no responsibility for that
20 problem?

21 A. Right. No, I'm on -- I have come to
22 believe that that is not right.

23 Q. What is right?

24 A. The pharmaceutical industry should accept
25 partial responsibility for the public health problem

1 that has emerged because they distilled from work
2 that was created in the time frame of this problem
3 evolving, all the positives, all the positive
4 messages and packaged that into marketing without
5 concurrently providing the medical community and the
6 public with the context and the kinds of education
7 related to risk to try to make sure that the
8 patients who had access to this drug were carefully
9 selected to minimize risk, that they had been
10 selective with this therapy only after other
11 approaches of pain management had not worked, and
12 that if this therapy was tried, it was tried
13 according to guidelines that were published
14 repeatedly during this period of time that pointed
15 to the need to be cautious in dosing, to evaluate
16 aberrant behavior, to react to aberrant behavior --
17 all of that messaging about proper patient
18 selection, about appropriate dosing, about
19 monitoring of drug-related behavior, about dealing
20 with problematic drug-related behavior, that
21 messaging was not included in many -- in much of the
22 marketing work that was done by the companies during
23 this period of time.

24 And I have come to believe that that's
25 in part what drove the kind of prescribing by a

1 segment of the physician community that presumably
2 could not select patients appropriately and led to a
3 high risk for patients, including the risk of
4 unintended overdose and mortality.

5 Q. I know that answer comes after a lot of
6 thought and having a lot of fingers pointed at you.

7 Let me ask you this. All the things you
8 just said of why these drug companies should bear
9 some responsibility, the reason they should accept
10 some responsibility, according to your personal
11 experience and qualifications dealing directly with
12 this issue is because their conduct was at least a
13 cause of the public health problem that you referred
14 to? That's true?

15 MR. ERCOLE: Objection to form.

16 THE WITNESS: That's right. Again, I've
17 come to conclude that their conduct in marketing
18 without context and without education about risk
19 produced an increase of inappropriate and unsafe
20 prescribing that contributed to the public health
21 problem.

22 BY MR. BECKWORTH:

23 Q. And the conduct you referred to was wrong,
24 according to you?

25 MR. ERCOLE: Objection to form.

1 THE WITNESS: Yes.

2 BY MR. BECKWORTH:

3 Q. And that includes the conduct of Purdue?

4 MR. ERCOLE: Objection to form.

5 THE WITNESS: Yes.

6 BY MR. BECKWORTH:

7 Q. Teva?

8 A. Yes.

9 MR. ERCOLE: Same objection.

10 BY MR. BECKWORTH:

11 Q. Cephalon?

12 A. Yes.

13 MR. ERCOLE: Same objection.

14 BY MR. BECKWORTH:

15 Q. Janssen?

16 A. Yes.

17 Q. And Johnson & Johnson?

18 A. Yes. Yes.

19 MR. BECKWORTH: Thank you, sir. I'll

20 pass the witness. I appreciate your time today. I

21 know that it's been a long, difficult day, and maybe

22 we'll have an opportunity to question you again.

23 Thank you.

24 Pass the witness.

25 MR. EHSAN: Do you want to take a five-

1 minute break?

2 MS. SPENCER: That's fine.

3 THE VIDEO OPERATOR: Off the record,
4 4:25.

5 (Recess at 4:25 p.m.,
6 resumed at 4:44 p.m.)

7 THE VIDEO OPERATOR: We're back on the
8 record, 4:44.

9 EXAMINATION

10 BY MR. EHSAN:

11 Q. Good afternoon, Dr. Portenoy. My name is
12 Houman Ehsan. I represent Janssen and Johnson &
13 Johnson, defendants in this case. I introduced
14 myself, I think, before the depo began, but that was
15 a long time ago.

16 I will be asking you some questions and
17 I will try to not retread any old ground, but I may
18 have to go back and clarify some points, if that's
19 okay with you.

20 A. Yes.

21 Q. Doctor, you're a resident of New York;
22 is that correct?

23 A. Yes.

24 Q. And you work at a New York hospital;
25 is that correct?

1 A. No. I work in a health system, a community-
2 based health system, not-for-profit, called MJHS.

3 Q. And is that based in New York?

4 A. Yes.

5 MS. SPENCER: I'm sorry. Houman, if you
6 can raise your voice just a little bit.

7 MR. EHSAN: Sure.

8 MS. SPENCER: I'm having a little
9 trouble hearing you.

10 MR. EHSAN: Absolutely.

11 BY MR. EHSAN:

12 Q. Do you pay any taxes in New Hampshire?

13 A. No.

14 Q. Do you own any property in New Hampshire?

15 A. No.

16 Q. As far as you know, do you have any
17 contacts besides your lawyer being located in New
18 Hampshire with New Hampshire?

19 A. No.

20 Q. And I understand that you drove up for this
21 deposition from New York; is that correct?

22 A. Yes.

23 Q. Must have been a long drive?

24 A. Yes.

25 Q. How long did that take you?

1 A. About four hours and 15 minutes.

2 Q. Doctor, have you had occasion to visit
3 Oklahoma?

4 A. No.

5 Q. Have you ever practiced medicine in
6 Oklahoma?

7 A. No.

8 Q. Have you ever been licensed to practice
9 medicine in Oklahoma?

10 A. No.

11 Q. Have you had interactions with physicians
12 you knew or to be from Oklahoma?

13 A. Not to my knowledge.

14 Q. Are you aware of the standards of care in
15 Oklahoma in regard to the management of pain today?

16 A. No.

17 Q. Were you aware of the standards of care as
18 it relates to the management of pain in Oklahoma at
19 any point in the past?

20 A. No.

21 Q. And you'd agree with me, doctor, that
22 standards of care for treatment vary somewhat from
23 community to community; is that correct?

24 A. Yes.

25 Q. Have you had occasion to see any materials

1 that any of the pharmaceutical manufacturers
2 distributed in the State of Oklahoma?

3 A. The answer is no.

4 Q. And let me be more specific.

5 A. Yes.

6 Q. You don't know which, if any, material was
7 specifically provided to any particular physician in
8 the State of Oklahoma, correct?

9 A. I do not.

10 Q. My understanding is, doctor, that you
11 provided a declaration to Mr. Beckworth and the
12 State of Oklahoma in connection with this particular
13 deposition; is that correct?

14 MR. BECKWORTH: Objection. The
15 declaration was provided to the State of Oklahoma,
16 not to any individual.

17 BY MR. EHSAN:

18 Q. Did you, Dr. Portenoy, provide a
19 declaration?

20 A. My attorney did.

21 Q. And that declaration, I believe your
22 testimony was, essentially answered substantively
23 identical to the one that you provided to plaintiffs
24 in a different litigation; is that correct?

25 A. Yes.

1 Q. It would be fair to say that it was
2 essentially a cut-and-paste with some minor edits
3 that we discussed today?

4 MS. SPENCER: Objection. That's
5 privileged.

6 BY MR. EHSAN:

7 Q. Doctor, did you give, yourself, any
8 additional edits or revisions between the version
9 that was submitted to plaintiffs in the other
10 litigation versus the declaration that was submitted
11 in Oklahoma?

12 A. No.

13 Q. Would it be fair to say that -- I believe --
14 and correct me if I'm wrong about this -- that you
15 engaged in significant revision and redrafting of
16 the declaration that was initially provided to the
17 other plaintiffs; is that correct?

18 A. That's correct.

19 Q. So whatever thinking process and drafting
20 process you engaged in, that got translated over to
21 the declaration in Oklahoma; is that correct?

22 A. Yes.

23 Q. Now, I also understood that you were not
24 sued in the State of Oklahoma; is that correct?

25 A. Not sued by the State of Oklahoma.

1 Q. Have you ever had any lawsuit from the
2 State of Oklahoma?

3 MS. SPENCER: Let's -- So are you
4 saying -- When you say "from the State of Oklahoma,"
5 do you mean by the Attorney General, or do you mean
6 by anyone within the State of Oklahoma? Because he
7 has been named in lawsuits in the State of Oklahoma,
8 but not by the State of Oklahoma.

9 MR. EHSAN: Let me apologize and let me
10 clarify the question.

11 BY MR. EHSAN:

12 Q. You provided the declaration to the State
13 of Oklahoma, correct?

14 A. My attorney did.

15 Q. Your attorney did. And as far as you know,
16 the State of Oklahoma has not filed a lawsuit
17 against you; is that correct?

18 A. That's correct.

19 Q. If the State of Oklahoma has not filed a
20 lawsuit against you, what was your understanding of
21 why you were providing a declaration to the State of
22 Oklahoma?

23 MS. SPENCER: I object to the extent
24 that that calls for privileged information.

25 MR. EHSAN: I'm not --

1 MS. SPENCER: You're not asking him to
2 say anything --

3 MR. EHSAN: Not the conversation.

4 BY MR. EHSAN:

5 Q. But my question is what motivation do you
6 have as Dr. Portenoy to provide that -- I'm not
7 asking you to divulge conversation with your
8 counsel -- but just your state of mind, what is your
9 understanding of why I'm handing this declaration to
10 Oklahoma?

11 A. My understanding is that in exchange for my
12 truthful testimony at the deposition and the
13 declaration, the State of Oklahoma will not take any
14 action against me in any of the opioid litigation.

15 Q. And did the State of Oklahoma provide you,
16 as far as you know, anything in writing to that
17 extent?

18 A. Not that I'm aware of. Oh, I -- I guess
19 I -- it was an email. I'm sorry. I misspoke.
20 There was an email to my attorney.

21 Q. So you anticipated my question here.

22 A. Emails are written.

23 Q. And I apologize. I'm going to have to dig
24 through some of these documents here.

25 So what is your understanding of what

1 the email from the State of Oklahoma implied for the
2 purposes of you being sued in the State of Oklahoma?

3 MS. SPENCER: Are you going to show him
4 a copy of an email?

5 MR. EHSAN: Yes. I'm trying to find it.
6 I'm just asking him what his recollection is.

7 BY MR. EHSAN:

8 Q. And if you need to see the email, I'll be
9 glad to give you the email.

10 MS. SPENCER: He needs to see the email.

11 MR. EHSAN: The problem with the end of
12 the day is that the documents kind of get unwieldy
13 here. But somewhere here we have -- Ah, there we go.

14 (Portenoy Exhibit 30 was marked
15 for identification.)

16 BY MR. EHSAN:

17 Q. Doctor, the court reporter has handed you
18 what's been marked as Exhibit 30 to your deposition.
19 Please take a moment to look at it. It's not a very
20 long email. And just let me know if this is the
21 email that you had in mind that you just testified
22 to.

23 A. I didn't -- I don't believe that I saw this
24 specific email, so I don't know if I had this email
25 in mind. I know that there was an email that

1 indicated that in exchange for my truthful testimony
2 and the declaration, that I wouldn't be considered.

3 Q. And the subject matter of this email is
4 "FYI," correct?

5 A. Yes.

6 Q. And it's from Mr. Beckworth to your
7 attorney, Ms. Amy Spencer, correct?

8 A. Yes.

9 Q. And it says -- the body of it states,
10 "Per your request, this email is to confirm that the
11 State does not plan to add your client to our suit."

12 Did I read that correctly, sir?

13 A. Yes.

14 Q. And is it fair to assume that "State" here
15 is referring to the State of Oklahoma?

16 A. Yes.

17 Q. And it goes on to say, "Also, before he
18 signs the final version, would you please delete the
19 word 'defendant' in para 39 re the 2009 APS
20 guidelines? As is, it indicates all of those listed
21 are named in our case but they are not."

22 Do you see that?

23 A. Yes.

24 Q. Were you aware that Mr. Beckworth was
25 suggesting edits to the declaration?

1 A. I wasn't aware that the edit was suggested,
2 but I was aware that there were some slight edits,
3 as we said before.

4 Q. And this email is dated January 16, and you
5 signed your declaration, I believe you testified, on
6 January 17 --

7 A. Yes.

8 Q. -- is that correct?

9 A. Yes.

10 Q. So once you became aware that the State was
11 confirming that it wasn't planning to add you to a
12 suit, that is when you executed the declaration,
13 correct?

14 A. Yes.

15 Q. Looking at the declaration itself, which I
16 believe is --

17 A. Exhibit 2.

18 Q. -- Exhibit 2. That's right. You've talked
19 a lot about this at various points, but I wanted to
20 draw your attention to a few items in it.

21 MS. SPENCER: And I'll make the same
22 request I made of opposing counsel. If you could
23 note where you are --

24 MR. EHSAN: Absolutely.

25 MS. SPENCER: -- and I can follow along.

1 MR. EHSAN: Absolutely.

2 BY MR. EHSAN:

3 Q. Just for the record, I note paragraphs 1
4 through 3 kind of set out some background
5 information -- or paragraphs 1 and 2 set out some
6 background information about your educational
7 training; is that correct, doctor?

8 A. Yes.

9 Q. Specifically looking at paragraph 3, which
10 is on page 3, it states in the declaration, "I have
11 agreed to cooperate with certain plaintiffs who have
12 entered into settlement agreements with me dismissing
13 me as a defendant in their cases ('settling
14 plaintiffs')." "

15 Do you see that?

16 A. Yes.

17 Q. But you do not have a settlement agreement
18 with Oklahoma, correct?

19 A. I do not.

20 Q. So this language about settling plaintiffs
21 seems somewhat inapplicable to the state of
22 Oklahoma; would you agree?

23 A. Yes.

24 Q. And it goes on to say, "Settling plaintiffs
25 agreed to dismiss me from their cases in exchange

1 for my truthful cooperation," correct?

2 A. Yes.

3 Q. And again, you're not settling with the
4 State of Oklahoma since they haven't named you in a
5 lawsuit, correct?

6 A. Yes.

7 Q. Nevertheless, did you understand that if
8 you didn't cooperate with the State of Oklahoma,
9 they may name you in a lawsuit?

10 A. Yes.

11 Q. And did that in any fashion or form
12 motivate you to provide them a declaration?

13 A. Well, the --

14 MR. BECKWORTH: Can I just object to one
15 thing so the record's clear. The State of Oklahoma
16 is not a "them." It's just an "it." So the reason
17 I'm making that is not to be picky, but there are
18 these subdivisions who filed suit, so just to be
19 clear what we're referring to.

20 MR. EHSAN: Sure.

21 MR. BECKWORTH: Thank you.

22 BY MR. EHSAN:

23 Q. So did the threat by the State of Oklahoma
24 to name you as a plaintiff in a lawsuit motivate you
25 to provide the State of Oklahoma the declaration?

1 MR. BECKWORTH: Objection. It's not
2 a -- there was no threat by the State of Oklahoma.
3 What you had asked him was, did he think there was a
4 threat he might be sued. The State of Oklahoma has
5 never threatened him. And there's no such evidence
6 in the record.

7 BY MR. EHSAN:

8 Q. I just note that when it's my turn to ask
9 questions, the State will object. So it's par for
10 the course for people to object when the other side
11 is asking questions.

12 That said, did you have an understanding
13 that if you did not cooperate with the State of
14 Oklahoma, the State of Oklahoma may, in fact, name
15 you in a lawsuit?

16 A. Yes. And I would be at risk for having
17 that happen, yes.

18 Q. And I believe, as you note in your -- maybe
19 not in here, but is it true, Dr. Portenoy, that
20 you're facing some financial difficulties?

21 A. Yes.

22 Q. And that you are on the precipice of
23 bankruptcy?

24 A. Yes. Yes.

25 Q. So there's potentially a significant

1 economic risk you face from being named in
2 additional lawsuits, including one perhaps in the
3 State of Oklahoma; would that be a fair assessment?

4 A. Yes.

5 Q. And did you consider those factors in
6 deciding whether or not to provide a declaration to
7 the State of Oklahoma?

8 A. I had an interest in not being named in
9 Oklahoma, yes. And the ability to offer truthful
10 testimony in exchange for that was an opportunity
11 that I definitely wanted to take because I am
12 covering all of my legal costs without any insurance
13 or any other coverage.

14 And the risk of going bankrupt as a
15 result of that is ever present with all of this
16 litigation. And the ability to offer truthful
17 testimony in exchange for not being named is an
18 opportunity that I will take.

19 Q. Did you -- and putting aside the email we
20 discussed and this declaration -- have any other
21 contact with the representatives of the State of
22 Oklahoma?

23 A. No.

24 Q. And I'm talking about before today.

25 A. No, I did not.

1 Q. Now, you state in paragraph 4 of your
2 declaration -- again, on page 3 -- Oh, I should ask.
3 Strike that. Let me go back and ask a different
4 question.

5 Are you aware of whether or not your
6 counsel had interactions with the State of Oklahoma
7 besides this email and the declaration itself?

8 MS. SPENCER: I'll object but he can
9 answer "yes" or "no."

10 THE WITNESS: Yes.

11 BY MR. EHSAN:

12 Q. Yes, you know that your counsel had other
13 contacts?

14 A. Yes.

15 Q. Do you have a rough sense of how many?

16 A. No.

17 Q. Do you know over what period of time?

18 A. Not really, no.

19 Q. Would you say that they went before, let's
20 say, November of 2018?

21 A. I wouldn't think it was that far back.

22 Q. You state in paragraph 4 that this
23 declaration is based on your personal knowledge;
24 is that correct?

25 A. Yes.

1 Q. So to loop back to a question I asked you
2 earlier, you have no personal knowledge of any
3 particular marketing effort by any pharmaceutical
4 manufacturer in the State of Oklahoma, correct?

5 A. Correct.

6 Q. In your declaration, you speak -- and
7 staying with that paragraph 4 -- I believe you said
8 you came to believe -- I'm reading on page 4 now,
9 the top of the page which is a continuation of
10 paragraph 4 -- "I also came to believe that opioid
11 manufacturers should have tempered their positive
12 messaging about opioids with a greater focus on
13 risk, particularly as early signs of opioid risk
14 emerged, and should have responded as evidence of
15 increasing adverse effects mounted in a more
16 aggressive manner to increase awareness and reduce
17 inappropriate or risky prescribing."

18 Do you see that topic?

19 A. Yes.

20 Q. When you're talking about pharmaceutical
21 companies' messaging, are you talking about their
22 labeling?

23 A. No.

24 Q. Are you talking about the -- Let me back up.

25 Do you know what REMS are, doctor?

1 A. Yes.

2 Q. What is your understanding of what REMS are?

3 A. "Risk evaluation and mitigation strategies."

4 Q. And what are REMS in terms of your daily --
5 in a daily practice related to risk mitigation
6 strategies?

7 A. If a REMS has been implemented by FDA,
8 it can have different criteria, different
9 characteristics. It depends on what's being risk
10 managed.

11 Q. Are you aware that scheduled narcotics have
12 a REMS program under the FDA currently?

13 A. Yes.

14 Q. And would it be fair to say that those --
15 that those REMS programs include educational
16 material mandated by the Food and Drug
17 Administration?

18 A. Yes.

19 Q. Do you have a suggestion -- or in your
20 experience, has there been any attempt to have
21 excess positive messaging in any of the REMS
22 educational material?

23 A. No, I don't believe so.

24 Q. We also talked a lot about the primary
25 literature or the published literature. You have

1 published extensively on chronic pain management;
2 is that correct?

3 A. Yes.

4 Q. Both in the cancer setting, also in a
5 noncancer setting, correct?

6 A. Yes.

7 Q. And just so we get some terminology correct,
8 "palliative care" is synonymous with "end-of-life
9 care"; is that correct?

10 A. No. Not anymore. Palliative care is a
11 subspecialty of medicine and nursing and social work
12 and chaplaincy, and it's related to interventions to
13 try to improve the quality of life with patients
14 with serious chronic illness.

15 Palliative care specialists like myself
16 tend to focus on patients with far advanced illness.
17 But palliative care as a model of care is
18 appropriate throughout the course of a serious
19 illness.

20 Q. Was there a time where palliative care was
21 considered synonymous with end-of-life care?

22 A. Yeah. In the '70s when it first emerged,
23 it was really synonymous with end-of-life care in
24 the cancer population, but there's been dramatic
25 change internationally since that time.

1 Q. And just so that we're also clear on
2 terminology, even if you have chronic pain from
3 cancer, it does not mean that you are necessarily a
4 terminal patient, correct?

5 A. That's correct.

6 Q. In fact, many people live with cancer for
7 an extended period of time; is that correct?

8 A. That's correct.

9 Q. And then the other terminology is "chronic
10 noncancer pain." And would it be fair to say that's
11 pain that lasts more than a period of time that's
12 somewhat debatable within the scientific community
13 but one that is not from a cancer origin; is that
14 correct?

15 A. Yes, that's true.

16 Q. And from a neurological perspective, is
17 there a difference to the way the brain perceives
18 cancer pain versus noncancer pain?

19 A. It's difficult to infer how the brain
20 perceives. So I'm not really sure how to answer
21 that question.

22 Q. Sure. Let me put it in slightly different
23 terms. Is a patient who's suffering from 10 out of
24 10 pain from cancer any different, in your mind,
25 from what they're experiencing versus a patient

1 who's suffering from 10 out of 10 pain that's from a
2 noncancer origin?

3 MR. BECKWORTH: Objection.

4 MS. SPENCER: You may answer.

5 THE WITNESS: So I have always thought
6 for 30 years that the difference between cancer pain
7 and noncancer pain relates more to the population
8 affected rather than to the pain itself.

9 So that the population with chronic
10 cancer pain tends to be older, it tends to be
11 patients with less -- a lower prevalence of comorbid
12 psychiatric pathology than the population with
13 chronic noncancer pain, particularly the common
14 types of chronic noncancer pain we were talking
15 about before: low back pain, neck pain, fibromyalgia,
16 myofacial pain.

17 Cancer pain syndromes related to tumor
18 invasion of different structures in the body have a
19 discrete path of physiology. More is being learned
20 about that all the time. But from the perspective
21 of managing the pain in the person who has cancer,
22 it's less about the fact that there's a tumor
23 producing an injury to the body than it is the
24 person who has that tumor producing the pain.

25 I don't know if I'm clear about that.

1 But I have -- I have always been -- always tried to
2 draw commonalities between patients with cancer pain
3 and noncancer pain and point to the need for
4 physicians to do a good, comprehensive assessment of
5 the patient without feeling that simply having a
6 tumor in the body means that there's no risk
7 associated with opioids and you can use them ad lib,
8 or assuming if there's no cancer in the body,
9 opioids are not to be used at all.

10 That dichotomy never made sense to me,
11 beginning really in my fellowship during the 1980s.

12 BY MR. EHSAN:

13 Q. So if I understood you correctly, you'd
14 make equal effort to treat a patient regardless of
15 the origin of his or her pain; would that be correct?

16 A. So if I'm understanding your question, of
17 course a clinician should make an equal effort to
18 treat pain irrespective of the etiology, irrespective
19 of the patient who has it. Of course, that's the
20 case.

21 But the decision about how to position
22 opioids, for example, similar to the position of the
23 question about how to position nerve blocks or how
24 to position stimulators of the brain -- all of those
25 questions about how to use therapies for chronic

1 pain are based on a comprehensive assessment that
2 goes beyond thinking that this pain is caused by a
3 tumor in the body and this pain is not.

4 It's based on the total picture, many
5 characteristics of the person who's experiencing
6 that pain.

7 Q. So if I understood you correctly, doctor --
8 and feel free to correct me -- that the source of
9 the pain is one piece of information.

10 However, the other factors that the
11 patient presents with, including age, comorbidities,
12 potentially social history, family history, genetics,
13 et cetera could all play a role in making a full
14 assessment of the patient's need and the appropriate
15 therapy for that patient?

16 A. Yes, that's what I'm saying.

17 Q. And would it be fair to say from your
18 perspective that unless you actually got to see the
19 medical records and preferably the patient him or
20 herself, that you can't just assess a patient for
21 appropriate therapy -- Strike that.

22 Would you agree with me, doctor, that
23 you can't assess a patient for appropriate
24 therapeutic intervention without at least seeing the
25 medical records and preferably the medical records

1 plus having the patient in front of you?

2 MR. BECKWORTH: Objection.

3 MS. SPENCER: You may answer.

4 THE WITNESS: Yes, I agree with that.

5 BY MR. EHSAN:

6 Q. And it's also true, doctor, that the
7 individual risk profile of a patient can oftentimes
8 outweigh the general risk profile of any particular
9 intervention?

10 A. You're going to have to clarify what you
11 mean by that question.

12 Q. Sure. So I think what we -- what
13 Mr. Beckworth spoke with you about was the fact that
14 there's a variability within the population about
15 the risk of addiction with long-term opioid use in a
16 noncancer setting and the numbers I believe you said
17 ran from less than 1 percent to significantly
18 higher. And the average, I think in your last
19 paper, was 4.7 percent; is that correct?

20 MR. BECKWORTH: Objection. That's not
21 his testimony.

22 MS. SPENCER: You can answer.

23 THE WITNESS: Yes. The last systematic
24 review and metaanalysis of studies that looked at
25 patients without a prior history of substance abuse

1 found an incidence of addiction of 4.7 percent.

2 BY MR. EHSAN:

3 Q. So that 4.7 percent is a general number.

4 But if you then know, for example, that that patient
5 is, for whatever reason, genetically susceptible,
6 that may override any consideration of that
7 4.7 percent because the individual patient risk
8 profile is such that it completely reshuffles or
9 recalibrates, to use your words, the risk/benefit
10 analysis of the prescriber; is that fair?

11 A. Yeah. I don't think that the general
12 number, what you called a general number before, is
13 clinically appropriate to make decisions on. It may
14 be appropriate to consider a range of therapies
15 based on -- based on a balance between expected
16 benefit and expected risk in a population of
17 patients.

18 I think physicians make those judgments
19 about all sorts of interventions every day. But the
20 decision to take a specific therapy and administer
21 it requires a benefit-versus-risk analysis of the
22 individual that has to consider a whole range of
23 considerations of the type that you mentioned
24 before.

25 Q. And likewise, the risk of addiction or

1 abuse or misuse of an opioid is not the only risk
2 that these medications carry; is that correct?

3 A. That's correct.

4 Q. And sometimes the other risk of these
5 medications -- for example, increased intracranial
6 pressure -- could be significantly more important to
7 a particular prescribing decision than the potential
8 risk of addiction; is that fair?

9 A. We wouldn't usually worry about increased
10 intracranial pressure during chronic therapy, but we
11 would worry about things like cognitive impairment,
12 the risk of falls, severe constipation, those kinds
13 of risks.

14 Q. Certainly those risks are separate and
15 apart from the addiction risk; is that fair?

16 A. Yes, that's true.

17 Q. And someone may be susceptible to a
18 different side effect of the medication irrespective
19 of where they sit on the abuse or addiction
20 potential; is that fair?

21 A. That is fair to say, yes.

22 Q. So when you -- do you still prescribe
23 opioids today?

24 A. Yes. I have a small -- a small practice at
25 this point.

1 Q. How many patients do you see on a given
2 week?

3 A. Oh. It's less than one per week.

4 Q. When you were last -- when were you last
5 seeing patients on a more regular basis?

6 A. It's been quite a few years since I had a
7 weekly practice. Probably at least 10 years. Maybe
8 even 12 years.

9 Q. Do you still believe that today in 2019
10 that in the right -- in the right patient, that
11 chronic opioid use can be effective in addressing
12 chronic noncancer pain?

13 A. Yes.

14 Q. Do you believe that in the right patient --
15 in the right patient, that the risk of addiction can
16 be outweighed by the benefits that the medication --
17 an opioid medication may provide to that patient?

18 A. Yes.

19 Q. Is it true that every patient who takes an
20 opioid develops dependence or abuse -- or goes on to
21 develop dependence or abuse?

22 A. That's a complex question because you've
23 combined --

24 MS. SPENCER: I object. That is
25 compound.

1 BY MR. EHSAN:

2 Q. Let me break it out. So -- one second and
3 I'll focus you on something. One moment.

4 Well, before I get there, let me ask you
5 something because I'm trying to follow your
6 declaration so that you can follow along.

7 If you look at paragraph 5 of your
8 declaration, which is also on page 4, you state
9 that, "I have observed" -- and it's the second
10 sentence -- "I have observed and treated numerous
11 patients with chronic pain, including those with
12 diverse noncancer disorders and those with cancer or
13 other life-limiting illnesses."

14 Do you see that?

15 A. Yes.

16 Q. So would it be fair to say you have chronic
17 pain patients whose diagnoses varied significantly
18 once you put cancer aside?

19 A. Yes.

20 Q. And have you had occasion to treat patients
21 with opioids for a variety of underlying diagnoses
22 for the cause of the chronic pain?

23 A. Yes.

24 Q. Do you think it would be appropriate --
25 it would be appropriate for someone to decide that

1 only certain diagnoses should be entitled to opioid
2 therapy and all other diagnoses should not?

3 A. I don't believe that that's the right
4 medical practice, no.

5 Q. Would you feel that it would be an intrusion
6 on the practice of medicine by a doctor to restrict
7 opioid medications, for example, to certain
8 categorical lists of diagnoses?

9 A. Yes, I would.

10 Q. Do you think it would be an intrusion on
11 the practice of medicine to say that a prescription
12 above a certain morphine milligram equivalent is
13 de facto unnecessary?

14 MR. BECKWORTH: Objection.

15 MS. SPENCER: You may answer.

16 THE WITNESS: Yes. I agree that it
17 would be inappropriate to do that.

18 BY MR. EHSAN:

19 Q. Ultimately, as we talked about, the best
20 people to make a decision about what's right for a
21 particular patient is -- are the doctor and that
22 patient sitting in that room with the most
23 information about the risks and the benefits to that
24 particular patient, correct?

25 A. Correct.

1 Q. If you were asked to assess whether or not
2 a colleague's prescription of an opioid to a patient
3 was medically necessary or not, could you do that
4 without looking at the medical record?

5 A. No.

6 Q. Could you do it -- Would you prefer to see
7 the patient?

8 A. I think that's a complex question. It
9 depends on what specific question is being asked.
10 I think evaluating a medical record and determining
11 that a physician is repeatedly assessing for
12 analgesia, for side effects, for functional
13 outcomes, and for aberrant drug-related behaviors
14 over time and reacting to the information that he or
15 she is collecting over time would be, to me, very
16 reassuring that the patient is being properly
17 managed.

18 I think if the question was more
19 challenging, like whether or not some aberrant drug-
20 related behaviors that were occurring that the
21 physician was trying to deal with -- whether or not
22 those behaviors represented the disease of addiction
23 or some comorbid psychiatric disorder, that sort of
24 subtle diagnostic challenge would require seeing the
25 patients.

1 Q. But at a minimum, the medical records and
2 possibly the patient him or herself?

3 A. Yes --

4 MR. BECKWORTH: Objection. Compound.

5 THE WITNESS: Yes. I would agree with
6 that.

7 MS. SPENCER: Okay.

8 BY MR. EHSAN:

9 Q. Can you recall some of the noncancer
10 diagnoses for which you have prescribed chronic
11 opioid therapy for in the past?

12 A. Sure. Yes.

13 Q. Can you just list those. What comes to
14 mind?

15 A. I have a long and extensive history in
16 treating patients with musculoskeletal problems like
17 chronic low back pain, chronic neck pain,
18 osteoarthritis pain, myofacial pain syndrome.

19 I have an extensive experience in
20 treating all types of neuropathic pain syndromes,
21 including central post-stroke pain, peripheral
22 neuropathy, posttraumatic neuralgia or posttraumatic
23 mononeuropathy.

24 And I've also had extensive experience,
25 as I mentioned before, in treating patients who

1 don't have cancer but have other serious chronic
2 illnesses such as patients who have advanced heart
3 failure, advanced pulmonary disease, who might have
4 chronic pain and might be considered a chronic
5 noncancer pain patient without recognizing that they
6 are more common -- they have characteristics that
7 make them more comparable to cancer pain population.

8 Q. And you've had occasion then to treat that
9 diagnosis you just listed with opioids in some
10 patients?

11 A. Yes.

12 Q. But certainly it's not necessary to treat
13 every one of those patients with opioids, correct?

14 A. Correct.

15 Q. You stated in 1986 -- now I'm moving on to
16 paragraph -- well, let me ask you to go to
17 paragraph 6. You said [as read], Prior and during
18 the 1980s, opioids were disfavored for use in
19 chronic noncancer pain because of concerns that
20 patients using opioids would develop tolerance and
21 physical dependence and would be at risk for abuse,
22 misuse, addiction, diversion.

23 Do you recall that?

24 A. Yes.

25 Q. I think at some point you said the medical

1 community was perhaps a little too hesitant to use
2 opioid medications even in cancer patients, much
3 less in chronic noncancer pain relative to what you
4 felt the data at the time supported; is that correct?

5 A. I would generalize that comment and say it
6 wasn't my opinion. It was the general opinion of
7 academics around the world looking at the problem of
8 cancer pain, that it was severely undertreated.

9 That, in fact, continues to be the
10 perception in much of the world, particularly in the
11 developing world, which was documented in a recent
12 publication called the Lancet Commission in 2017,
13 which documented the continuing undertreatment of
14 cancer pain, even in patients with advanced illness
15 today.

16 So the problem of undertreatment didn't
17 begin then and it didn't end after opioids were
18 being used more in chronic undertreatment of
19 populations, even where there's broad agreement that
20 this is the treatment that should be given, it
21 continues even today.

22 Q. Are you talking just outside the United
23 States or including the United States?

24 A. This -- studies that have been done in the
25 United States that have tried to evaluate the

1 appropriate use of opioid therapy for cancer pain
2 using a metric continue to show undertreatment in
3 the United States at high rates.

4 Q. So even today for the use of opioids to
5 treat chronic pain associated with cancer is still
6 less than where the scientific literature would
7 suggest it needs to be; is that correct?

8 A. Yes.

9 Q. And you believe that that is a detriment to
10 patients who are suffering from pain who are not
11 being adequately treated?

12 A. Yes, I do.

13 Q. If those individuals were to be treated
14 adequately for pain, would that include perhaps
15 using opioids for the treatment of their condition?

16 A. Yes. In 2019 broadly, there's still
17 agreement that the analgesic ladder concept for
18 cancer pain should still apply to patients who have
19 active metastatic disease and pain or who have
20 advanced chronic illnesses or advanced serious
21 illnesses of other types.

22 And what the analgesic ladder guideline
23 for pain says essentially is that any patient with
24 chronic moderate to severe pain should receive an
25 opioid. And the specific type of opioid selected

1 might vary depending on whether or not the patient
2 has moderate or severe pain or whether or not the
3 patient had prior trials with specific drugs.

4 But the general concept that was
5 promulgated through the analgesic ladder approach
6 since the mid 1980s is that moderate to severe pain
7 related to active cancer should be treated with an
8 opioid as the mainstay therapy.

9 Q. So despite these medications that we've
10 talked about today having been out for, in some
11 cases, a decade plus, and despite marketing that
12 we've discussed throughout today, there are still
13 individuals who are getting undertreated for
14 legitimate cancer pain for which you believe chronic
15 opioid use is warranted?

16 A. Yes, I believe that's the case.

17 Q. So would you agree with me, doctor, that
18 that suggests that the marketing of these opioids
19 did not have a 100 percent effect on getting
20 everyone to accept the appropriateness of these
21 drugs in the, at least, cancer context --

22 MR. BECKWORTH: Objection.

23 BY MR. EHSAN:

24 Q. -- is that fair?

25 MR. BECKWORTH: Sorry. I didn't mean to

1 speak over you. Were you done?

2 MR. EHSAN: Yeah.

3 MR. BECKWORTH: Objection, form.

4 MS. SPENCER: You may answer.

5 THE WITNESS: All the marketing that has
6 been done did not resolve the problem of undertreated
7 cancer pain in the United States. That's true.

8 BY MR. EHSAN:

9 Q. How about noncancer pain? Are there
10 individuals today in the United States who suffer
11 from chronic noncancer pain who are undertreated for
12 their condition?

13 A. It's a complex question. Because in order
14 to designate a population of patients as being
15 undertreated, you have to have a consensus that the
16 treatment is appropriate and you have to have data
17 to say what the level of appropriate treatment is.

18 And in the very heterogenous population
19 with chronic noncancer pain, all those separate
20 diagnoses that I talked about before, we have
21 neither the consensus nor do we have a standard of
22 what appropriate level of treatment would be, based
23 on any science.

24 So it's very difficult -- and I have
25 been saying this for many, many years -- it's very

1 difficult to designate a population with chronic
2 noncancer pain as being undertreated.

3 However, beginning in the 1980s and
4 extending forward, the effort to consider the use of
5 an opioid therapy in patients with treatment
6 refractory pain -- pain that hasn't resolved with
7 other types of treatments, hasn't resolved with
8 physical therapy, that sort of patient -- that
9 effort to make that treatment available was viewed
10 as the right thing to do because the experience in
11 cancer pain and the data that were accumulating
12 based on the epidemiology of risk suggested that the
13 undertreatment of those patients -- or I'm sorry --
14 the lack of treatment of those patients in every
15 case is inappropriate.

16 So the effort on my part, really
17 beginning since 1986, is to try to create educational
18 messages and simple guidelines that physicians can
19 follow to try to select patients who may be able to
20 benefit, may have benefit greater than risk, and
21 then to have the skills necessary to try the opioid,
22 monitor the outcomes carefully, and for those
23 patients who continue to benefit and don't
24 demonstrate the risk, continue that therapy long
25 term.

1 Q. I think you alluded to something that I was
2 going to ask you about, is that sometimes once
3 you've identified a particular patient you think may
4 be suitable for opioid -- long-term opioid therapy,
5 you still have no a priori evidence going in whether
6 or not the drug is going to give them the results
7 you hoped to give them and you must be essentially a
8 trial and error to see if the medication, in fact,
9 works; is that correct?

10 A. That's totally correct.

11 Q. So even if you prescribe a medication for a
12 patient and it turns out that it doesn't work for
13 them or they suffer a negative adverse effect from
14 the drug, it doesn't necessarily mean that the
15 initial prescribing decision was a mistake, but
16 rather that the trial and error just produced a
17 negative result; is that correct?

18 A. That's correct.

19 Q. Now, you also mentioned that in addressing
20 the patient's pain before you get to opioids -- you
21 talk about physical therapy and some other medication
22 options -- is it true that availability of insurance
23 coverage can effectively hinder your ability to
24 prescribe certain nonopioid regimens for your
25 chronic pain patients when you were practicing --

1 A. Yes.

2 Q. -- more regularly? I apologize. And I
3 think you alluded to the word "access." So I wanted
4 to kind of dig in on that a little bit.

5 In order for a patient to have access to
6 a Schedule II narcotics -- a Schedule II narcotic,
7 he or she must go to a doctor who has a DEA license,
8 correct?

9 A. Go to a clinician who is able to prescribe.
10 It could be a physician, it could be a nurse
11 practitioner.

12 Q. Are you aware of nurse practitioners being
13 able to prescribe Schedule II narcotics?

14 A. Yes.

15 Q. And in addition to just having the
16 prescription, there's the issue of whether or not
17 it's available in a particular pharmacy, correct?

18 A. Yes.

19 Q. And even if it's prescribed and available
20 at a particular pharmacy, then in order for -- if
21 it's going to be reimbursed, it has to be within the
22 formulary structure for that particular patient,
23 correct?

24 MR. BECKWORTH: Objection.

25 MS. SPENCER: You may answer.

1 THE WITNESS: That's correct.

2 BY MR. EHSAN:

3 Q. And even if it's formulary, it may not
4 necessarily be affordable, depending upon its
5 position within that formulary structure, correct?

6 A. That's correct.

7 Q. So there are lots of different facets that
8 control access to Schedule II narcotics, correct?

9 A. Yes.

10 Q. That would be also true for Schedule III
11 and IV narcotics, correct?

12 A. Yes.

13 Q. So even if -- even if a patient, for
14 example, went to his or her doctor and said, I want
15 to be prescribed a Schedule II narcotic and even if
16 the physician agreed that that would be the best
17 doesn't necessarily mean that that patient has that
18 option depending on the particular -- particular
19 facts associated with insurance coverage, financial
20 means, and other factors, correct?

21 A. Yes. That's true.

22 Q. Are you aware to what extent the State of
23 Oklahoma from 1996 to present has attempted to
24 control or dictate availability of certain
25 Schedule II narcotics within its Medicaid population?

1 A. No.

2 Q. Are you aware that most states administer
3 their Medicaid insurance programs?

4 A. Yes.

5 Q. And Medicare is run by the federal
6 government, correct?

7 A. Yes.

8 Q. And there's also private insurance?

9 A. Yes.

10 Q. So you have no knowledge of what the State
11 of Oklahoma has or has not done in relation to
12 allowing access or lack thereof for opioids to
13 patients under the Oklahoma Medicaid program,
14 correct?

15 A. That's correct. I don't know.

16 Q. Would that be relevant to you in assessing
17 whether or not the State of Oklahoma could have done
18 more in order to help lessen the number of
19 inappropriate prescriptions that perhaps may have
20 been written in the State of Oklahoma?

21 A. I'm not sure that I can say that. I don't
22 have enough information about the kinds of tools
23 that the State would have had in order to influence
24 those outcomes. So I can't say that that's true.

25 Q. So, for example, I think you mentioned that

1 if a doctor saw a promotional material that
2 necessarily didn't emphasize the risks, but did
3 emphasize the positives of a narcotic, he or she may
4 be influenced by the promotional material; is that
5 correct?

6 A. Yes.

7 MS. SPENCER: I'll object. It wasn't
8 exactly his testimony. But I'll let him answer.

9 BY MR. EHSAN:

10 Q. If you want to correct me, please do so.

11 A. No. I think the gist of what you said,
12 I would agree with.

13 Q. Do you have actual personal knowledge of
14 anyone in the State of Oklahoma who was influenced
15 and prescribed an opioid inappropriately after
16 having seen some promotional material?

17 A. No, I don't.

18 Q. So putting aside the fact that you don't
19 have any specifics in mind, if that -- if the State
20 of Oklahoma, for example, had restricted the use of
21 opioids for more than, let's say, three months to
22 certain diagnoses, that would potentially curb the
23 ability of that physician to continue to prescribe
24 that patient an opioid, correct?

25 A. Yeah. If a rule existed of the type you

1 said in which -- a rule that basically stated that a
2 physician had a three-month window to prescribe,
3 after which the patient would not be able to access
4 the drug, then that would certainly influence what
5 happened to that patient. Absolutely.

6 Q. Likewise, if the State of Oklahoma
7 implemented a plan that after -- the patient had to
8 be reevaluated every 30 days, that could alter the
9 physician's prescribing decision on a going-forward
10 basis, correct?

11 A. I think that's theoretical. It's possible.
12 But I'm not sure.

13 MR. EHSAN: We'll get back to that in a
14 minute.

15 (Portenoy Exhibit 31 was marked
16 for identification.)

17 MR. EHSAN: I did not want to speak
18 while her hands were busy with something else.

19 MS. SPENCER: Sorry. Yes, thank you.

20 BY MR. EHSAN:

21 Q. Doctor, I've handed you what -- or the
22 reporter has handed you what's been marked as
23 Exhibit 31 to your deposition.

24 Do you recognize this document?

25 A. Yes.

1 Q. How do you recognize it?

2 A. It was an article that I and my colleague,
3 Kathleen Foley, wrote in 1986.

4 Q. Now, I believe, if you look at paragraph 7
5 of your declaration, you talk at some length about
6 this particular article; is that correct?

7 A. Yes.

8 Q. And you report on a group of patients that
9 were selected from two separate pools, I believe, of
10 patients. And you report on their rate of symptom
11 relief as relates to their pain on opioids as well
12 as some aberrant and potentially addictive behavior;
13 is that correct?

14 A. Yes.

15 Q. Sitting here today, do you believe that the
16 substance of this article, as you reported it, are
17 accurate?

18 A. Yes.

19 Q. And do you agree that since -- and this was
20 published in a peer-reviewed journal; is that
21 correct?

22 A. Yes.

23 Q. So that means other physicians or medical
24 professionals with knowledge of publications and
25 studies had reviewed it and provided their, at least

1 acceptance of it as worthy of publication, correct?

2 A. Yes.

3 Q. And would you agree with me, doctor, that
4 if a physician -- or let me strike that.

5 Would you agree with me that someone who
6 has the authority to prescribe an opioid, that, to
7 use your words, has the responsibility to be aware
8 of the risks and benefits of the medication he or
9 she is prescribing?

10 A. Yes.

11 Q. And one source of information would be the
12 primary literature, correct?

13 A. Yes.

14 Q. And a physician who is capable -- or a
15 health care professional who's able to prescribe
16 would be able to read your article and understand
17 it, correct?

18 A. Yes.

19 Q. The reason I ask, you don't need to be a
20 specialist in order to read a journal article,
21 correct?

22 A. Correct.

23 Q. They're broken down in a pretty standard
24 format with methods, results, discussion, and a
25 conclusion, correct?

1 A. Yes.

2 MR. BECKWORTH: Objection.

3 BY MR. EHSAN:

4 Q. And that the methods section should clearly
5 lay out what it is that you attempted to do and
6 give some information about the limitations,
7 methodological limitations of the article; is that
8 correct?

9 A. Limitations are not usually included in the
10 methods section. They're usually discussed further
11 in the article in sort of the standard format that
12 they use.

13 Q. You anticipated my next question. So just
14 reading -- I'll take you, Dr. Portenoy. If when you
15 read an article -- myself, I always read the methods
16 first. But when you read an article, do you read
17 the methods section?

18 A. Yes.

19 Q. And before you get to the discussion of the
20 limitations in the discussions section, can you
21 already ascertain whether or not the methods were of
22 good quality, moderate quality, poor quality?

23 A. Yes.

24 Q. So the methods section, even though it
25 specifically doesn't discuss the limitations, allows

1 the educated reader to be able to assess what kind
2 of study this is and what would be potential risk --
3 the positives and negatives of this kind of study,
4 correct?

5 MR. BECKWORTH: Objection.

6 MS. SPENCER: You can answer.

7 THE WITNESS: Yes.

8 BY MR. EHSAN:

9 Q. So someone reading your article in 1986
10 would realize that it had, for what it was, data
11 that relates to a certain number of cases that you
12 report with certain restrictive limitations from the
13 methodology involved, but also nevertheless, that it
14 represented some data to take into consideration in
15 connection with the risk of abuse and addiction in
16 chronic opioid use --

17 MR. BECKWORTH: Objection.

18 BY MR. EHSAN:

19 Q. -- is that correct?

20 MR. BECKWORTH: Sorry. Objection.

21 Can I ask y'all a question real quick?

22 MR. EHSAN: Sure.

23 MR. BECKWORTH: I'm going to let you
24 choose since this is maybe a trial depo. Do you
25 want me to lay out 16 different objections or are

1 you good with "Objection"?

2 MR. EHSAN: "Object to form" is fine.

3 MR. BECKWORTH: Okay. Very good.

4 Everybody else agree to that?

5 MR. COLEMAN: Yes.

6 MR. BECKWORTH: Brian?

7 MR. ERCOLE: Yes. "Object to form."

8 THE WITNESS: Could you ask the question
9 again.

10 BY MR. EHSAN:

11 Q. Sure. Let me ask the question again.

12 So anybody reading this article would be able to
13 understand it represents data with certain
14 limitations about the risk of opioid addiction in a
15 group of patients, correct?

16 MR. BECKWORTH: Objection.

17 BY MR. EHSAN:

18 Q. Sorry. Opioid addiction in a group of
19 patients?

20 MR. BECKWORTH: Objection.

21 MS. SPENCER: Can you go back and ask --
22 Let's start from square one.

23 THE WITNESS: I'm confused too.

24 BY MR. EHSAN:

25 Q. So if someone read your article in 1986,

1 would they be able to understand that it provided
2 data on a group of 38 patients, correct?

3 A. Yes.

4 Q. And whether or not a certain number of
5 those patients received benefit from chronic opioid
6 therapy, correct?

7 THE WITNESS: Yes.

8 MR. BECKWORTH: Objection.

9 BY MR. EHSAN:

10 Q. And whether or not a certain number of
11 those patients received -- or had problematic
12 behavior associated with their opioid use, correct?

13 A. Yes.

14 MR. BECKWORTH: Objection.

15 BY MR. EHSAN:

16 Q. And all of that is laid out in the paper,
17 correct?

18 A. Yes.

19 Q. And specifically, if you look -- Oh, yes --
20 if you look at Table III on page 175 as paginated --

21 MR. BECKWORTH: Objection. Sorry.

22 I missed it. I'm objecting because I didn't hear
23 the question.

24 MR. EHSAN: I just asked him to look at
25 page 175.

1 MR. BECKWORTH: I know you did. I was
2 talking to his counsel, so I just lodged it to make
3 sure I didn't miss something. I withdraw it.

4 BY MR. EHSAN:

5 Q. If you're there, let me know, doctor.

6 A. I'm here.

7 Q. The article itself sort of lays out the
8 duration of use by the patients in the study,
9 correct?

10 A. Yes.

11 Q. And it also lays out the average morphine
12 milligram equivalent dose that the individuals were
13 taking in the study, correct?

14 A. Yes.

15 Q. By the way, in 1986 when this was published,
16 what were the available long-acting opioid
17 medications in the United States?

18 A. I mean, to my recollection --

19 MS. SPENCER: Only answer if you know.
20 If you recall.

21 THE WITNESS: Yeah. I don't recall.

22 BY MR. EHSAN:

23 Q. Do you have a recollection that methadone
24 was available?

25 A. Yes.

1 Q. Besides methadone, can you think of any
2 other drugs?

3 A. I can't, no.

4 Q. Neither could I, but I just wanted to make
5 sure that we were on the same page. So all of these
6 patients who were taking various medications, none
7 of them were on a long-acting opioid that is at
8 issue in this litigation, correct?

9 A. Correct.

10 Q. As a pain specialist, do you have a sense
11 or an experience that long-acting opioids are better
12 suited than short-acting or immediate-release
13 opioids for the treatment of chronic pain?

14 A. That's a complex question. I will say that
15 for some years after the advent of the long-acting
16 opioids, the pain expert community felt that they
17 were an advantage because of the likelihood of a
18 higher rate of adherence to the therapy. Patients
19 would miss fewer doses because of the possibility of
20 sleeping through the night, and because patients
21 would have higher satisfaction.

22 But since that time, there have been
23 studies done trying to determine whether a long-
24 acting regimen and a short-acting regimen vary in
25 outcomes. And the studies have never been able to

1 show that, to my knowledge.

2 So today -- if you're asking me today in
3 2019 is there good evidence that a regimen of long-
4 acting therapy is better than a regimen of short-
5 acting therapy, I don't think that evidence exists.

6 Q. Let's talk a little bit about that evidence
7 that you alluded to. Are there controlled --
8 placebo-controlled randomized clinical trials of
9 opioids going out beyond 52 weeks?

10 A. Not to my knowledge, no.

11 Q. Are there randomized placebo-controlled
12 clinical trials of any other pain medication we use
13 going out more than 52 weeks in assessment of pain?

14 A. Not that I'm aware of.

15 Q. So we're not in a world in which we have
16 randomized clinical trials that go on forever and
17 ever that could actually answer the question of what
18 happens to a patient in terms of efficacy and, you
19 know, potential side effects going out many years in
20 a controlled environment, correct?

21 A. That's correct.

22 Q. And there are lots of logistical reasons
23 why those studies haven't been done, correct?

24 A. Yes.

25 Q. Can you identify some?

1 A. Yes. It's very challenging to do a long-
2 term study of chronic opioid therapy against placebo
3 because a study like that, first of all, would be
4 very difficult to recruit patients to, patients that
5 would have to not get treated for a long period of
6 time.

7 It's also very challenging because the
8 population that may be treatable with opioids isn't
9 clearly defined. As I said before, there's no
10 standard of a patient -- a type of patient with
11 chronic noncancer pain that should get an opioid.
12 So all of those questions about what the selection
13 criteria would be would be challenging to define.
14 It's not going to be a population. It's going to be
15 individuals within that population.

16 It's also -- it's also difficult to
17 envision that a study would go out for a long time
18 without a high dropout rate. And a high dropout
19 rate, particularly if it was unbalanced, more
20 dropouts among the placebo group than among the
21 active treatment group would make it very difficult
22 to do the analysis.

23 So the combination of difficult
24 recruitment, heterogeneity of the population, and
25 difficulty in maintaining the therapy over time, all

1 of that increases the challenge of a long-term study
2 tremendously. And as you said, the studies of that
3 type have not been done.

4 Q. So we're living in a world of imperfect
5 data; is that fair?

6 A. That's absolutely fair.

7 Q. Even though we don't have a randomized
8 clinical trial, placebo controlled going out for
9 52 weeks or more, we still do have data that can
10 inform the decision of a prescriber of whether or
11 not to prescribe an opioid both in terms of safety
12 and efficacy, correct?

13 A. Yes.

14 Q. And I think we talked about quality of
15 data. Just because something is of lesser quality
16 doesn't mean that it has no value, but it has to be
17 taken in the context that it has more potential
18 shortcomings than if it was of a higher quality
19 nature; is that correct?

20 A. It's a little bit more complex than that.
21 Because the quality of the data -- and I should say,
22 as you probably know -- that the field of evidence-
23 based medicine is very new. It only began in the
24 1990s.

25 And the whole concept of evaluating the

1 quality of research, the quality of the methodology
2 of a piece of research in order to have a -- in
3 order to grade the level of evidence.

4 And the whole process of taking -- I'll
5 continue -- and the whole process of looking at high
6 methodological quality studies and lower
7 methodological quality studies and combining them
8 into what's called a grade of recommendation for
9 clinical practice, that's something that's now done
10 in the development of evidence-based guidelines.

11 But that didn't exist until recent
12 decades. In other words, that's a new change in
13 medical practice.

14 So what you said is true in the sense
15 that a decision about using a therapy needs to be
16 based on whatever high quality data exists, even if
17 that high quality data doesn't provide much evidence
18 that informs long-term practice.

19 So, for example, a short-term efficacy
20 trial that demonstrates that the opioid works is
21 foundational information. You have to have that to
22 know that the drug works. But that trial doesn't
23 inform long-term practice very well because the
24 patients who are entered into that trial are not
25 like the patients who get long-term therapy.

1 And because the therapy only goes on for
2 sometimes two weeks and sometimes at the most three
3 months and you don't get the kind of information
4 that informs what's now called effectiveness. In
5 other words, the real life ability of the drug to be
6 given to a patient in a way that is likely to
7 produce more benefit than risk.

8 That information, whether or not a drug
9 should be used long term, has to take that efficacy,
10 that high quality data, and combine it with all the
11 other information in the literature, including
12 expert testimony from people who just have
13 experience using the drug.

14 Q. So you're good at expecting my follow-up
15 question. So one additional piece of information
16 one could rely on after you have that foundational
17 piece would be the real world experience of
18 prescribers who have used the medicine in real world
19 patients, correct?

20 A. Yes.

21 Q. I think you mentioned several places in
22 your declaration that even if you had a long-term
23 study, because randomized clinical trials have a
24 very rigid structure to minimize confounding
25 variables, they don't necessarily translate directly

1 to real-world patients because they may be much more
2 complicated or a mixed heterogenous group; is that
3 correct?

4 A. That's correct.

5 MR. BECKWORTH: Objection.

6 THE WITNESS: That's correct.

7 BY MR. EHSAN:

8 Q. And, in fact, in your paper, you speak
9 about the fact that you have -- or perhaps it was
10 elsewhere, so let me back up.

11 In your declaration, you talk about the
12 fact that you have experienced patients taking
13 long-term opioids for chronic noncancer pain who
14 have had significant relief from their symptoms,
15 at least in your clinical practice, correct?

16 A. Yes.

17 Q. And that means at least for that patient,
18 that the therapy worked, correct?

19 A. Yes.

20 Q. And that is some evidence that can be
21 communicated to other prescribers that they may
22 consider in making their own prescribing decision,
23 correct?

24 A. You know, in our current era, you wouldn't
25 call that evidence. You would call that sort of an

1 expert testimony or an anecdotal observation. So if
2 you're asking me, do anecdotal observations that are
3 analyzed by people who have experience help
4 physicians make decisions, the answer is yes.

5 That still happens today and even in an
6 era of evidence-based medicine, and I think that's
7 always going to happen because you can never get
8 enough evidence to actually inform all the varieties
9 of conditions that are encountered in clinical
10 practice.

11 Q. And as someone who had by the '90s a
12 significant amount of experience in treating
13 patients with long-term opioid therapies, you were
14 considered one of those experts who could help
15 inform fellow physicians about the real world risks
16 and benefits of these medications, correct?

17 A. Yes.

18 MR. BECKWORTH: Objection.

19 THE WITNESS: Yes.

20 BY MR. EHSAN:

21 Q. And would it be fair to say you did in fact
22 take that endeavor to inform your fellow colleagues
23 about the risk and benefit of long-term opioid
24 therapy?

25 A. Yes.

1 Q. And during that time, to the best of your
2 knowledge at the time you were making statements,
3 did you always try to be truthful about what it was
4 you were saying?

5 A. Yes.

6 Q. And looking back at it today -- Well, let
7 me strike that and move --

8 Would you agree with me, doctor, that
9 medicine evolves?

10 A. Yes.

11 Q. You trained in neurology in the '80s, so
12 that was before TPA was available for the treatment
13 of stroke?

14 A. Yes.

15 Q. So I imagine that today how we treat a
16 stroke is very different than the way you may have
17 treated it in your residency training, correct?

18 A. Yes.

19 Q. That doesn't mean that what you did in the
20 '80s was bad or somehow you were doing something
21 wrong, rather that we have more sophisticated
22 approaches today than we did back then, correct?

23 A. Correct.

24 Q. Likewise, you may have made a statement
25 about, you know, what is the state of science in

1 1990, which may be very different because -- than
2 the statement you would make today because the
3 science has changed, correct?

4 A. Correct.

5 MR. BECKWORTH: Objection.

6 BY MR. EHSAN:

7 Q. That doesn't make either statement false.
8 It just makes them appropriate for the time that
9 they were given, correct?

10 A. Yes.

11 MR. BECKWORTH: Objection.

12 BY MR. EHSAN:

13 Q. So when you were talking to folks in the
14 context of discussions you had about chronic
15 long-term opioid use, you always gave them fair and
16 balanced information; is that correct?

17 A. Yes. I tried to.

18 Q. And you've given those -- I just want to
19 separate two separate topic areas. Because I think
20 there was some conflation here between CMEs, which
21 are continuing medical education events; is that
22 correct?

23 A. Yes.

24 Q. And promotional speaking engagement, okay?

25 A. What are now called that.

1 Q. What are now called that?

2 A. What are now called those.

3 Q. Names change. But we'll stick with the CME
4 first.

5 A. Yes.

6 Q. In the context of a CME, who had control
7 over the content?

8 A. The speaker.

9 Q. So if it was you who was speaking, it would
10 have been you, correct?

11 A. Yes.

12 Q. Now, is it possible for a pharmaceutical
13 company to directly or indirectly provide financial
14 support for a CME?

15 A. Yes.

16 Q. In your experience, has a pharmaceutical
17 company ever dictated to you the content of a CME
18 where you disagreed about a particular point?

19 A. No.

20 Q. And there are strict rules and regulations
21 about disclosures when it comes to a CME, correct?

22 A. Yes. And as I mentioned before, those too
23 have been evolving over the years. Now they're
24 quite strict. They were less strict in the '80s and
25 '90s.

1 Q. I'm sorry. Please finish.

2 A. I think that was the statement I wanted to
3 make. Thank you.

4 MR. EHSAN: And just to kind of drive
5 this point . . .

6 MS. SPENCER: Are we done with the 1986
7 article?

8 MR. EHSAN: For now, yes.

9 (Portenoy Exhibit 32 was marked
10 for identification.)

11 BY MR. EHSAN:

12 Q. Doctor, the reporter has handed you what's
13 been marked as 32, I believe?

14 A. Yes.

15 Q. Exhibit 32. I'll give you as much time as
16 you like to look at it. But just looking at the
17 cover, do you recognize what it is?

18 A. Yes.

19 Q. And what is your recollection of what it is.

20 MS. SPENCER: I would give -- give me a
21 second to look at it and give him a moment to
22 familiarize himself with it.

23 MR. EHSAN: Sure.

24 MS. SPENCER: Thanks.

25 THE WITNESS: Yes.

1 MR. EHSAN: I'm just waiting for your
2 counsel to be finished.

3 MS. SPENCER: Sorry, just one moment.

4 MR. EHSAN: I think you have her at an
5 advantage because she's not familiar with it,
6 so . . .

7 I will comment because this has nothing
8 to do with it. You look a fair bit younger in the
9 picture.

10 MR. BECKWORTH: You were.

11 MS. SPENCER: Okay.

12 BY MR. EHSAN:

13 Q. Doctor, if I understand this correctly,
14 this is a CME, or continuing medical education
15 program you and Dr. Payne put together, which has at
16 least a release date on this document of June of
17 2002; is that correct?

18 A. Yes.

19 Q. That's a good name for a pain specialist.

20 A. Yes.

21 Q. Now, in the second page of this, you will
22 see -- or just the backside -- it's double-sided --
23 it states, "This activity is funded through an
24 educational grant from Janssen Pharmaceuticals L.P."

25 Do you see that?

1 A. Yes.

2 Q. It goes on, "The content was developed
3 independently by the contributing faculty."

4 Do you see that?

5 A. Yes.

6 Q. Is that a correct statement?

7 A. Yes.

8 Q. And it goes on to have a discussion or a
9 "Dear Colleagues" letter signed by you and Dr. Payne;
10 is that correct?

11 A. Yes.

12 Q. And you state there, "Pain is a complex and
13 challenging phenomenon and varies in etiology and
14 presentation and requires individual treatment."

15 Do you see that?

16 A. Yes.

17 Q. Would you agree with that statement today?

18 A. Yes.

19 Q. If you go to what is numbered 7 in the
20 document, do you see there's a section titled,
21 "Curriculum committee and disclosures"?

22 A. Yes.

23 Q. And you are identified on the top right-
24 hand column, correct?

25 A. Yes.

1 Q. And there you identified all sources of
2 funding and current consulting agreements you have,
3 correct?

4 A. Yes.

5 Q. So this, even as of 2002, the -- a CME
6 would require disclosure of the grant funder as well
7 as the disclosure of any potential conflicts that
8 the curriculum committee members might have,
9 correct?

10 A. Yes.

11 Q. And is it your opinion that at any time a
12 CME course that you were involved in did not
13 adequately provide the positives and negatives
14 associated with the use of opioids in chronic
15 noncancer pain?

16 A. I think that the courses that I did aimed
17 to do that, to present the balanced view.

18 Q. I'm not asking about perfection, but at
19 least the idea was to present a fair and balanced
20 sense of the science as it relates to chronic -- or
21 use of opioids in chronic noncancer pain, correct?

22 A. Yes.

23 Q. Are you, sitting here today, aware of any
24 colleague -- Let me strike that and ask you this way.

25 Sitting here today, are you aware of any

1 CME course that you are not involved in that you
2 believe did not adequately represent the risk and
3 the benefit of opioid therapy in chronic noncancer
4 patients?

5 MR. BECKWORTH: Objection.

6 MS. SPENCER: You can answer.

7 THE WITNESS: I can only speak to the
8 CME activities that I attended. And I don't --
9 I never had that experience of watching a CME
10 program and feeling that it was presenting
11 information that was improper.

12 BY MR. EHSAN:

13 Q. So at least based on your experience,
14 regardless of whether you gave the presentation or
15 you attended the presentation, you believed that
16 over time they have for their particular time period
17 provided an appropriate risk/benefit picture of
18 opioid therapy and chronic noncancer pain, correct?

19 MR. BECKWORTH: Objection.

20 THE WITNESS: Yes. For CME activities,
21 I think that's true.

22 BY MR. EHSAN:

23 Q. Is there a restriction on who can attend a
24 CME?

25 A. No.

1 Q. You, yourself have attended CMEs in which
2 other experts in the field of pain medicine were
3 giving the presentations?

4 A. Yes.

5 Q. Is there a Q&A session associated with
6 these CMEs?

7 A. Usually, yes.

8 Q. Did you ever feel like you couldn't
9 challenge a particular speaker if you felt like he
10 or she was misrepresenting any particular fact or
11 piece of literature?

12 A. No.

13 Q. Are there times where there's actually
14 heated debate or discussions within a CME about what
15 the literature does or doesn't show?

16 A. I don't recall ever witnessing any. There
17 would be no reason that it couldn't happen, of
18 course, but I've never seen one.

19 Q. But this is meant to -- the CMEs are meant
20 to be an open scientific exchange between
21 professionals both presenting and in the audience,
22 correct?

23 A. Yes.

24 Q. Now, those are CMEs. Now let's talk about
25 the promotional side of things. I believe you said

1 that some of the promotional -- Well, strike that.

2 Have you had occasion to deliver
3 promotional speaking engagements?

4 A. Once that dichotomy was formalized,
5 I didn't do any promotional activities, any
6 promotional lectures that I recall. Prior to that
7 formalized distinction between promotional and CME,
8 I think some of the lecturing that I did would
9 probably be called promotional now.

10 Although I will say that I've never used
11 slides, for example, that were created by -- by an
12 industry contractor or by someone who was employed
13 by a company. I would always use my own slides.

14 And I never gave a talk where I was
15 informed by either someone working for a
16 pharmaceutical company or someone working for a
17 medical education vendor about what to say and what
18 not to say. I never have had that experience.

19 But having said that, as you know, the
20 rules about what you call CME and what you call
21 promotional are quite strict now. And if you go
22 back in time prior to when those rules existed,
23 I probably gave some talks that would be called
24 promotional now, even though my activities, I always
25 felt, were representing my true opinion and I

1 controlled the content.

2 Q. So let me try to unpack that. So at least
3 in your experience, irrespective of whether CME or
4 non-CME, irrespective of what label it was, if you
5 gave a talk, in your mind, you presented the
6 scientific data fairly and appropriately; is that
7 correct?

8 A. Yes. I believe that's true.

9 Q. With the caveat, of course, that the state
10 of science has evolved over time, correct?

11 A. Yes.

12 Q. Have you ever attended -- so we talked
13 about CMEs -- something that wouldn't be considered
14 a CME by today's standards wherein someone presented
15 material you felt were -- was inappropriate or
16 unbalanced in terms of the risk or the benefit for
17 the use of opioid therapy in chronic noncancer pain?

18 MR. BECKWORTH: Objection.

19 MS. SPENCER: You can answer if you
20 understand or --

21 BY MR. EHSAN:

22 Q. I can ask again.

23 A. No, I think I understand. I don't think
24 that I can recall a lecture of that type. So I
25 can't say that I actually personally observed that.

1 Q. So sitting here today, you never had any
2 direct interaction in which either in a CME setting
3 or non-CME setting, either as a speaker or a
4 nonspeaker, i.e., in the audience, you were exposed
5 to what you believe were unbalanced or inappropriate
6 discussions of the risks and benefits of opioids in
7 chronic noncancer pain, correct?

8 MR. BECKWORTH: Objection.

9 THE WITNESS: I can't remember -- I can't
10 recall observing that. So I would agree with that
11 statement.

12 BY MR. EHSAN:

13 Q. So I will try to break that down and ask it
14 simpler. You never sat in any CME course in which
15 the presenter presented materials that were
16 unbalanced or inappropriate in light of the science
17 on use of opioids for chronic noncancer pain,
18 correct?

19 MR. BECKWORTH: Objection.

20 MS. SPENCER: Go ahead. You can answer.

21 THE WITNESS: Yeah. Not that I can
22 recall.

23 BY MR. EHSAN:

24 Q. Likewise, you never gave a CME in which you
25 presented information that was unbalanced or in any

1 way inappropriate reflection of the scientific
2 literature as it relates to opioid use for chronic
3 noncancer pain, correct?

4 A. Correct.

5 Q. In the setting of the educational material
6 or promotional material speaking engagements, you
7 never attended a promotional speaking engagement in
8 which unbalanced or inappropriate information was
9 conveyed to the use of opioids for chronic noncancer
10 pain, correct?

11 A. I don't recall doing that, right.

12 Q. And likewise, to the extent some of your
13 speaking work may be considered promotional by
14 today's standards, in none of those instances did
15 you provide an unbalanced or inappropriate
16 assessment of the literature as it relates to opioid
17 use for chronic noncancer pain, correct?

18 MR. BECKWORTH: Objection.

19 MS. SPENCER: You can answer.

20 THE WITNESS: Correct.

21 BY MR. EHSAN:

22 Q. Now, when you publish an article, is it
23 your hope that physicians in the community would
24 read your paper?

25 A. I think that's a complex question. Depends

1 on the nature of the article. The community varies
2 in terms of who you hope you're contributing to. In
3 some cases, a piece of research, for example, is
4 being published in the hope that it's actually going
5 to be evaluated by a very small cadre of people
6 doing that kind of science because you're trying to
7 move the science forward.

8 When I write a paper that's a review
9 article, particularly a paper that's a review
10 article that includes guideline statements, then the
11 hope is that it disseminates more broadly, and you
12 have the hope of improving practice and helping more
13 patients by providing individuals with the skill set
14 that they didn't have before.

15 Q. Specifically as it relates to your 1986
16 paper when you were hoping to start a discussion
17 about the use of opioids in chronic noncancer pain,
18 did you hope that it would have a broad audience?

19 A. Yes.

20 Q. So would you have found it problematic if
21 someone were to hand a prescribing physician a copy
22 of your article?

23 A. No. Although I think that, again, the
24 question there is context. As I said before, if an
25 article was being handed in order to market a

1 specific product or with the intent of trying to
2 convince a prescriber to prescribe, without the
3 primary end being to educate that person or to have
4 that patient -- that person more aware -- raising
5 the consciousness of the potential -- the need to
6 rethink opioid therapy, which was really the goal of
7 that early, early paper, it was out there to say, We
8 think this because the stigma attached to opioids,
9 the risk profile that you think exists may be
10 exaggerated and you may be denying large numbers of
11 patients with the potential of some pain relief by
12 having a better understanding of the pharmacology
13 and the evidence.

14 If that was the aim of distributing the
15 paper, that would be fine, of course. If the aim
16 was to convince the prescriber to prescribe as part
17 of a marketing strategy, I would have a problem with
18 that.

19 Q. Would you agree with me that the first
20 thing that would have to happen is for the prescriber
21 to read the article, correct?

22 A. The first thing for what to happen?

23 Q. In order for it to have any impact
24 whatsoever on the prescriber, the prescriber would
25 have to read the article, correct?

1 A. I'm not sure that I can answer that. You
2 know, you're asking a challenging question. In
3 other words, to what extent are full articles of
4 this type, reviews, read and digested and analyzed
5 by people who don't have the same expertise versus
6 to what extent are they reading the abstract and
7 then looking at the guidelines. I don't really know
8 the answer. I can't really -- I can't really answer
9 that for you.

10 Q. So sitting here today, you have no idea
11 whether anyone was provided any of your articles as
12 part of an attempt to market, quote/unquote, to him
13 or her -- actually was influenced one way or the
14 other by the inclusion of your article in that
15 material; is that fair?

16 A. I would have no way --

17 MR. BECKWORTH: Objection.

18 Go ahead.

19 THE WITNESS: I would have no way of
20 knowing whether or not they were influenced.

21 BY MR. EHSAN:

22 Q. So to address Mr. Beckworth's objection,
23 sitting here today, do you have any knowledge of any
24 prescriber being influenced one way or the other by
25 the inclusion of any of your articles in any

1 marketing material presented to that prescriber?

2 MR. BECKWORTH: Objection.

3 THE WITNESS: I have --

4 MS. SPENCER: You can answer.

5 THE WITNESS: I have no evidence -- no
6 information about that specifically, that's true.

7 BY MR. EHSAN:

8 Q. But you personally prefer that that not be
9 done?

10 A. As part of marketing?

11 Q. Yes.

12 A. Yes. I would personally prefer that my
13 articles not be distributed as part of marketing,
14 but rather as part of education.

15 Q. Would you agree that physician education
16 can itself increase physician awareness and
17 potentially lead to more prescribing?

18 A. Yes.

19 Q. So, therefore, educating physicians and
20 marketing don't have to necessarily be separate and
21 mutually exclusive of one another, correct?

22 MR. BECKWORTH: Objection.

23 THE WITNESS: I'm going to have to ask
24 you to deconstruct that. I'm not sure how to
25 interpret that question.

1 BY MR. EHSAN:

2 Q. Sure. If -- for example, if you are saying
3 currently in the United States there are certain
4 chronic -- or certain cancer patients who are
5 undertreated for their pain.

6 So if you were to educate those
7 physicians who see those patients about the benefits
8 of opioid therapy for that cancer pain, that would
9 necessarily lead to some additional prescriptions
10 being written because now you're treating an
11 untreated, as of the moment, population, correct?

12 A. I would say that would hopefully lead to
13 that. It may not --

14 Q. It may --

15 A. -- lead to that. One would hope that it
16 would.

17 Q. So purely educating a physician can itself
18 be something that translates to that physician
19 reassessing his or her patients either to potentially
20 increase or decrease depending on what the exact
21 nature of the education piece is of -- or strike
22 that.

23 Educating a physician can help that
24 physician make better patient decisions as it
25 relates to prescribing, correct?

1 A. Correct.

2 Q. And you have no problem with that, correct?

3 A. I -- Correct. I don't have a problem with
4 that.

5 Q. And are you -- I know you were shown some
6 documents which I've never seen before. And I
7 raised this -- Strike that.

8 You mentioned context is important.

9 Do you recall that testimony?

10 A. Yes.

11 Q. So sometimes you were shown in this
12 deposition documents you'd never seen before,
13 correct?

14 A. Correct.

15 Q. Some of those were internal company
16 documents, correct?

17 A. Correct.

18 Q. And they used language that you were
19 specifically pointed to, correct?

20 A. Yes.

21 Q. Do you have any personal knowledge of why
22 particular words were used in any of those documents?

23 A. No.

24 Q. Do you have any understanding of the
25 natural -- or strike that.

1 Do you have any understanding of the
2 course of business in which the companies maintain
3 or assess or internally -- Strike that too because
4 it gets compound.

5 Do you have any sense of what the
6 companies were trying to achieve with any of the
7 documents that you read beyond just the words that
8 were there and being asked to interpret those words
9 as best as you could?

10 MR. BECKWORTH: Objection.

11 MS. SPENCER: You can answer.

12 THE WITNESS: I had not seen those
13 documents before. And the understanding that I said
14 when I was here just reflected my interpretation of
15 the plain language of the document.

16 I have no information about what went --
17 what went before that document in terms of the
18 process by which the document was created or the
19 thinking that went into the policies in the document
20 or the statements in the document. But I just
21 looked at the document and commented based on that.
22 That's all my information.

23 BY MR. EHSAN:

24 Q. Would it be fair to say you lacked any
25 context for the document beyond the written word of

1 the document?

2 MR. BECKWORTH: Objection.

3 THE WITNESS: Yes, that's true.

4 BY MR. EHSAN:

5 Q. Would you have liked to have seen some
6 context to better understand perhaps why certain
7 length was used in certain documents?

8 A. I think that's again a complicated question.
9 The question is, what am I being asked in -- as you
10 know, in today's deposition, I was being asked
11 whether or not the use of materials as part of a
12 marketing strategy -- in other words, whether or not
13 the events depicted on this document, were they to
14 occur -- would represent a problem for me. And I
15 acknowledged that they would be.

16 I think if you were asking me what I
17 thought about the actual marketing campaign and the
18 outcomes it had, I'd need a lot more information and
19 context. But I wasn't judging that today.

20 Q. But if you don't like a particular word,
21 for example, you have no basis to know why that
22 particular word was used, correct?

23 A. Right.

24 Q. And in order to know if that word was just
25 jargon versus have some deeper meaning, you would

1 need more context, correct?

2 A. Yes.

3 Q. And you certainly don't have any idea what
4 was in the minds of the individuals who prepared
5 that material, correct?

6 A. Right. I have no idea.

7 Q. I think you mentioned somewhere in your --
8 in your declaration that there was a term "street
9 addicts" that you regretted it; do you recall that?

10 MS. SPENCER: Where are we?

11 MR. EHSAN: That's a good question.

12 MS. SPENCER: You know, maybe I can
13 help.

14 MR. EHSAN: If you can just search, yes.

15 MS. SPENCER: Perhaps paragraph 12?

16 MR. EHSAN: That may well be true.

17 MS. SPENCER: Or at least that's -- Yes,
18 it's paragraph 12.

19 BY MR. EHSAN:

20 Q. My question was a simple one. You, in
21 retrospect, wished you had used a slightly different
22 word, right?

23 A. Yes.

24 Q. But there was no sinister intent behind the
25 use of that word, correct?

1 A. Correct.

2 Q. You were trying to communicate a concept
3 using words that, in retrospect, there could have
4 been better words chosen, correct?

5 A. Correct.

6 Q. So context matters in that -- in terms of
7 interpreting what those words mean and your intent
8 associated with them, correct?

9 A. Yes.

10 Q. Now, I want to go to your paragraph 9,
11 which is -- and specifically page 8. And I believe
12 this is a table from your 1990 paper; is that
13 correct?

14 A. Yes.

15 Q. And you here identify, I think, a -- and
16 I'm using my word here -- a framework for evaluating
17 and potentially prescribing and monitoring a patient
18 on chronic opioid therapy; is that correct?

19 A. Potentially prescribing opioid therapy to a
20 chronic noncancer pain patient, yes.

21 Q. So this is a framework by which if you're
22 going to prescribe a patient opioid for chronic
23 noncancer pain, this framework would allow you to go
24 through that process as a prescriber, correct?

25 A. Yes.

1 Q. Now, I was struck by the fact that this was
2 written in 1990, which is 28 years ago. But sitting
3 here today, would you agree with me that this is
4 actually the same process you would follow in 2019?

5 A. Yeah. I think overall as a framework, yes,
6 it has stood up to the test of time.

7 Q. So while other things may have changed,
8 some aspects of practice of medicine haven't really
9 changed a whole lot in the sense that assessing your
10 patient properly, following them carefully, and
11 assessing the benefits and the risk as you observe
12 it in that patient is always a good idea, correct?

13 A. Yes.

14 Q. Now, looking at this set of -- or this
15 framework, would you agree with me that a primary
16 care physician would be able to follow Steps 1
17 through 11?

18 A. Yes. I think the primary care physician
19 would have to have education, would have to have
20 understanding of opioid pharmacology in order to
21 prescribe the drug safely, to know what dose to
22 select, to how to increase the dose, how to treat
23 the side effects.

24 And they'd have to have some
25 understanding about how to assess the potential for

1 abuse and addiction, at least in order to avoid
2 those -- prescribing to the patients who had a high
3 risk. So it presumes a certain skill set on the
4 part of the primary care doctor.

5 Q. And presumably a -- not -- Let me back up
6 and ask it this way.

7 Do all primary care physicians prescribe
8 opioids?

9 A. No.

10 Q. Even amongst those who prescribe opioids,
11 do all of those individuals prescribe Schedule II
12 narcotics?

13 A. No.

14 Q. So it would take someone who make -- it
15 would take the primary care physician a conscious
16 effort to be able to and, in fact, prescribe a
17 Schedule II narcotic, correct?

18 A. By "conscious effort," do you mean a
19 decision?

20 Q. A decision.

21 A. Self-assessment of the skill set saying,
22 I'm able to do this and then a decision to try it?

23 Q. Yes.

24 A. Yes, I would agree with that.

25 Q. So it's not like, for example, you know --

1 Let me strike that.

2 It's not like prescribing, for example,
3 a nonsteroidal because that's something almost every
4 person would prescribe? This is a self-selected
5 group of individuals who may want to prescribe a
6 Schedule II narcotic, yes?

7 A. Yes. I think there are commonalities even
8 in the prescribing of an NSAID, a nonsteroidal of
9 the type you mentioned. You still have to know
10 whether or not it's likely to be safe in the patient
11 that you're prescribing. You still have to have a
12 skill set for selecting the drug and giving the
13 right dose.

14 But the complexity of using opioids
15 safely and effectively is much higher than the
16 complexity to use an NSAID safely and effectively.
17 So the skill set that the clinician would have to
18 perceive that he or she possessed would have to be
19 greater in order for that decision to be made to go
20 forward with therapy.

21 Q. And in the case of the opioid -- actually,
22 I should take that back. In the case of either, at
23 a minimum, you would expect a prescriber to read the
24 prescribing information for the medication, correct?

25 A. I don't know honestly whether or not the --

1 and by "prescribing information," I'm assuming you
2 mean the package insert.

3 Q. Yes.

4 A. And if you're asking me, is it standard
5 practice for every -- for the prescribers to read
6 the package insert before they decide to use a drug,
7 I can't answer that question. I don't know if
8 that's true.

9 Q. No, my question was a little bit more
10 generic than that. Is it your -- is it your -- as a
11 person who regularly treats pain patients, is it
12 your hope that a person who's going to endeavor to
13 start prescribing Schedule II narcotics, that he or
14 she would take the time to actually read the package
15 insert or label for the medication he or she's going
16 to prescribe to his or her patient?

17 MR. PATE: Object to form.

18 THE WITNESS: I would say it's my
19 expectation that they would have the information
20 necessary to prescribe the drug safely and
21 effectively. That information could be in the
22 package insert. It could be in other educational
23 materials.

24 BY MR. EHSAN:

25 Q. So it is your hope that anyone who's going

1 to prescribe a Schedule II narcotic would have the
2 necessary skills and efficiency to actually
3 prescribe that medication to a patient, correct?

4 A. Correct.

5 Q. And if that person has the necessary skill
6 and knowledge to prescribe, would that necessarily
7 mean that he or she has an understanding of the
8 risks and the benefits of the medication?

9 A. Yes.

10 MR. PATE: Object to form.

11 BY MR. EHSAN:

12 Q. Therefore, if someone was to follow the
13 Dr. Portenoy method of prescribing an opioid --

14 MS. SPENCER: I'm going to object to
15 that. I don't know what you're describing as "the
16 Dr. Portenoy method."

17 MR. EHSAN: Sure. Let me back up.

18 BY MR. EHSAN:

19 Q. If someone were to take the approach or
20 have the skill set that you identified before
21 prescribing, he or she would already know both the
22 benefits, or potential benefits, as well as the
23 potential risks of the medication, correct?

24 MR. PATE: Object to form.

25 MS. SPENCER: You can answer.

1 THE WITNESS: Yes. But again, I'd like
2 to point out that it's a complex and evolving
3 situation. The guidelines that are taught now or
4 should be taught in terms of the skill sets required
5 for safe and effective prescribing are different
6 than these guidelines and are different than the
7 guidelines that predated those.

8 So the knowledge of what constitutes
9 safe and effective prescribing changes as we learn
10 more about the drug, we get more experience with the
11 drug. And that's one of the challenges with opioids.
12 There are types of side effects of opioids that now
13 are of concern that didn't even raise concern in the
14 1980s. There was nothing known about them.

15 So I think the bottom line is that the
16 answer to your question on my part would be, yes,
17 you have to know that. But it's not a simple
18 process. It's an evolving question.

19 And there's always the question about
20 what is the core knowledge, what is the essential
21 knowledge versus less essential knowledge that the
22 primary care doctor, for example, would need to have
23 in order to prescribe.

24 BY MR. EHSAN:

25 Q. And I appreciate your -- I appreciate your

1 caveat. So let me try to ask a better question.

2 At any given point in time, a physician,
3 by your assessment, who is adequately prepared to
4 prescribe the medication would know the risks and
5 the benefit of the medication, correct?

6 MR. PATE: Object to form.

7 THE WITNESS: They would know -- they
8 should know the expected risk, the common risks.
9 They may not know the risks that -- every risk
10 that's listed in the package insert, which as you
11 know from reading many package inserts are extensive
12 lists of risks. Most of which are so uncommon that
13 we have no sense that we need to inform the patient
14 about.

15 They may not know about risks that are
16 beginning to appear in the literature, but are not
17 common risks or are not commonly recognized risks
18 yet across the broad universe of prescribers.

19 So to simply say they need to know the
20 risks and the benefits, I think you do have to
21 attach caveats to them. They need to know what the
22 expected benefit would be and they need to know how
23 to achieve that expected benefit pharmacologically,
24 which means they need to know how to dose and they
25 need to know how to treat side effects.

1 And they also need to know what the risk
2 profile is and how to monitor for the common risks,
3 including the pharmacological risks like constipation
4 and mental clouding and the risks that I call
5 abuse-related risks, which would be aberrant
6 drug-related behavior that may indicate addiction,
7 it may indicate drug abuse, it may indicate a
8 comorbid psychiatric disorder, it may even indicate
9 diversion. That they need to know.

10 BY MR. EHSAN:

11 Q. And would it be fair to say that even if
12 you know the benefits of the medication and the risk
13 of the medication, the individual statistics are
14 always zero or one.

15 And let me clarify what I mean. The
16 medication will either work or it won't work; is
17 that correct?

18 A. That's correct.

19 Q. And you either will have a side effect or
20 you won't have a side effect, correct?

21 A. That's correct.

22 Q. So -- and I bring this back to if you have
23 a 3 percent mortality risk of surgery, that doesn't
24 mean 3 die, 3 percent. That means 3 people die
25 100 percent and 97 people don't die at all. That's

1 an important facet.

2 So even if you understand the general
3 literature, you still don't necessarily know how
4 your patient's going to, in fact, react positively
5 or negatively to the medication you're prescribing,
6 correct?

7 A. Right.

8 Q. And that is part and parcel of your
9 recommendation to continue to monitor the patient
10 for the negative aspects as well as the positive
11 aspects of treatment, correct?

12 A. Correct.

13 Q. And would you agree with me that the
14 package insert includes all the risks of the
15 medication, at least known or known enough for the
16 FDA to allow the manufacturer to put it in the label?

17 MR. BECKWORTH: Objection.

18 THE WITNESS: Yes. I would agree with
19 that.

20 BY MR. EHSAN:

21 Q. So one place to get the risk information
22 and all its details would be in the package insert,
23 correct?

24 A. Yes.

25 MR. BECKWORTH: Objection.

1 BY MR. EHSAN:

2 Q. And I think you had mentioned that up -- in
3 the mid 2000s, industry didn't do enough to step up
4 and recalibrate its message as it relates to the
5 risk of abuse associated with opioids.

6 Do you recall that testimony?

7 A. Yes.

8 MR. EHSAN: I want to show you a product
9 label.

10 (Portenoy Exhibit 33 was marked
11 for identification.)

12 BY MR. EHSAN:

13 Q. Doctor, I'll just represent to you that
14 this is a package insert for Duragesic transdermal
15 fentanyl from 2005.

16 I want to ask you only about the boxed
17 warning, so you don't need to --

18 A. Okay.

19 MS. SPENCER: Can he just take a look
20 at --

21 MR. EHSAN: Sure, by all means.

22 BY MR. EHSAN:

23 Q. I guess my first question would be, is this
24 consistent with the label you recall for this
25 medication circa 2005?

1 A. Yes.

2 MR. BECKWORTH: Does it have a date on
3 it somewhere?

4 MR. EHSAN: At the very end, I believe
5 it should. Yes. It says "Janssen 2003."

6 MR. BECKWORTH: Well, that's a copyright
7 for your logo. That doesn't indicate where this
8 document came -- what year it might be.

9 MR. EHSAN: Let me go back up higher.

10 MS. SPENCER: I would agree that that's
11 important.

12 MR. EHSAN: Well, I will represent that
13 this is the label for 2005. But that's okay. We
14 can just pull up the label online and I will let you
15 confirm from the FDA's actual website that is, in
16 fact, the label for it.

17 MR. BECKWORTH: Well, so just so it will
18 help you out and get through this --

19 MR. EHSAN: Uh-huh.

20 MR. BECKWORTH: -- you're going to pull
21 up a label from the website that is for a specific
22 year?

23 MR. EHSAN: Yes.

24 MR. BECKWORTH: Or for just the label as
25 it is today?

1 MR. EHSAN: The label for 2005.

2 MR. BECKWORTH: Okay. And so are you
3 wanting him to read that versus this one?

4 MR. EHSAN: No. To confirm that the
5 boxed warning is identical. I'm not looking for the
6 rest of the document. I'm only doing this just so
7 that you don't think that I am trying to
8 misrepresent something.

9 MR. BECKWORTH: And just to be clear,
10 I'm not suggesting you are.

11 MS. SPENCER: Yeah.

12 MR. BECKWORTH: I just have no way to
13 know what you're saying is actually correct.

14 MS. SPENCER: And likewise, I had no
15 reason to believe that you were trying to
16 misrepresent anything either, just that I can't
17 allow my client to adopt a date as of 2005 unless he
18 can say so with absolute certainty that that's when
19 it came from unless he can confirm that it is
20 identical.

21 And respectfully, I can't let him adopt
22 a document as from 2005 just based on the box
23 information. I mean, if it's that important that
24 it's from 2005, he would need to confirm that the
25 entirety of the document is from 2005.

1 MR. EHSAN: So it's your position that
2 he can't -- Well, let me ask the question of the
3 doctor.

4 BY MR. EHSAN:

5 Q. Did you prescribe Duragesic in the 2005
6 time period?

7 A. I think it's highly likely that I did.

8 Q. Do you recall the labeling for Duragesic in
9 2005?

10 A. No.

11 Q. Then my problem is, the FDA's website has
12 this document. So you're saying that I can't trust
13 the FDA because the FDA didn't label the . . .

14 MS. SPENCER: Well, if the FDA website
15 says that it's from 2005, then I can allow him to
16 agree with you that the FDA website says it's from
17 2005.

18 MR. EHSAN: That's fine.

19 MS. SPENCER: But if he doesn't have a
20 recollection that that's when it's from, I cannot
21 allow him to adopt as his recollection that -- and
22 that he agrees it's from 2005.

23 MR. EHSAN: That's fine. I will just
24 represent to you.

25 MS. SPENCER: If I can just finish.

1 MR. EHSAN: Sure.

2 MS. SPENCER: I'll allow him to accept
3 that that's what the website says. And even if
4 that's what you say the website says. But I just
5 can't allow him to say, Yes, this is the document
6 from 2005.

7 BY MR. EHSAN:

8 Q. I'm not asking the question whether this
9 document is from 2005. I just want to orient you
10 that -- I will represent to you it's from the mid
11 2000s but you don't have to take my word for it.

12 A. Right.

13 Q. Now, doctor, looking at the first bolded
14 section, is that what is commonly referred to as a
15 boxed warning?

16 A. Yes.

17 MR. BECKWORTH: And I'm going to object
18 to using a document referencing any date when it's
19 not substantiated.

20 BY MR. EHSAN:

21 Q. Doctor, could you read the first bulleted
22 paragraph, please.

23 A. "Duragesic contains a high concentration of
24 a potent Schedule II opioid agonist, fentanyl.
25 Schedule II opioid substances which include

1 fentanyl, hydromorphone, methadone, morphine,
2 oxycodone, and oxymorphone have the highest
3 potential for abuse and associated risk of fatal
4 overdose due to respiratory depression. Fentanyl
5 can be abused and is subject to criminal diversion.
6 The high content of fentanyl in the patches . . .
7 may be a particular target for abuse and diversion."

8 Q. Would you agree with me, doctor, that
9 that's a pretty succinct statement regarding
10 potential risk of abuse, diversion, and even
11 respiratory problems associated with the use of
12 Duragesic?

13 A. Yes.

14 Q. If this was the boxed warning in the 2005
15 label, would you agree with me that in the mid
16 2000s, the drug companies had, in fact, put out
17 clear information in their label that identifies the
18 potential risk of abuse and/or overdoses with
19 Duragesic?

20 A. Yes.

21 Q. And is that the kind of thing you would
22 want to see?

23 A. Yes.

24 Q. If you go down just a little bit further,
25 it states that "Duragesic is indicated for the

1 management of persistent," underlined, comma,
2 "moderate to severe chronic pain that:"

3 Do you see that?

4 A. Yes.

5 Q. And the first bullet says, "requires
6 continuous around-the-clock opioid administration
7 for an extended period of time, and" -- both
8 conditions -- "cannot be managed by other means such
9 as nonsteroidal analgesics, opioid combination
10 products, or immediate-release opioids."

11 Did I read that correctly, doctor?

12 A. Yes.

13 Q. So if a doctor were to prescribe this
14 medication on-label, i.e., according to the
15 instruction provided in the label, that would mean
16 that it would only be prescribed for a patient that
17 had already failed other medication therapies,
18 including opioids, and required around-the-clock
19 opioid therapy, correct?

20 A. Yes.

21 Q. So this would be unlikely to just be
22 someone's first prescription for an opioid, correct?

23 A. Correct. If they were to follow the label.

24 Q. So would you agree that a physician who was
25 going to prescribe a Duragesic patch would have

1 available to him or her this warning in bold with
2 every package that he or she had -- Strike that.

3 The prescribing physician who was going
4 to prescribe Duragesic had available to him or her
5 this language in the prescribing information,
6 correct?

7 A. Yes. It would be available -- it used to
8 be available in a book called the PDR. And then it
9 was available online.

10 Q. Right. So it was available in a book
11 called the Physician's Desk Reference, correct?

12 A. Yes.

13 Q. I'm not sure about 2005, but at some point
14 it became available online, correct?

15 A. Correct.

16 Q. It is also actually folded and included
17 with the medication itself, correct?

18 A. Correct.

19 Q. Would you agree, doctor, that the
20 information presented in this label would be an
21 adequate warning or adequate transmittal of
22 information regarding the risks of Duragesic to a
23 prescriber who is going to prescribe it for a
24 patient?

25 A. I think the -- I would just hesitate on the

1 word "adequate."

2 So it would certainly alert the
3 physician that there are inherent risks that can be
4 very significant with this drug, including risks on
5 the abuse and addiction side and the risks on the
6 pharmacological side such as respiratory depression.

7 So a physician who read this and
8 absorbed this should be alerted that the drugs
9 are -- that the decision to prescribe is a
10 significant decision with the potential for serious
11 toxicity. And then you would hope that that
12 consciousness would translate into a comprehensive
13 assessment of the patient so that the physician can
14 make a judgment about what the risk versus benefit
15 would be in that individual.

16 Q. And sitting here today, do you have a
17 recollection of other opioid drugs having -- other
18 Schedule II narcotics having similar language and
19 boxed warnings sometime in the 2000s?

20 MR. BECKWORTH: Objection. What drugs?

21 MR. EHSAN: Schedule II opioids.

22 MR. BECKWORTH: Janssen drugs or other
23 people's?

24 MR. EHSAN: Let me ask my question if
25 you don't mind.

1 MR. BECKWORTH: Sure.

2 MR. EHSAN: You can object if you like.

3 BY MR. EHSAN:

4 Q. Did you prescribe Schedule II narcotics in
5 the 2000s?

6 A. Yes.

7 Q. Are you aware generally of the labeling for
8 those medications?

9 A. Yes.

10 Q. Do you recall having seen similar language
11 in boxed warnings for other Schedule II narcotics in
12 the 2000s?

13 A. Yes.

14 Q. And do you have occasion to prescribe --
15 Strike that.

16 Now, when you were talking about
17 promotional speaking engagements, do you have an
18 understanding of what the requirements for those
19 promotional speaking engagements are today?

20 A. I can't say that I do, no.

21 Q. Would it surprise you to know that the
22 labeling dictates what can be talked about in a
23 promotional speaking engagement?

24 MR. BECKWORTH: Objection.

25 THE WITNESS: I wouldn't be surprised.

1 I think that -- I didn't know that the labeling
2 circumscribed what could be said. But I'll accept
3 what you say. And it seems reasonable.

4 BY MR. EHSAN:

5 Q. So let me just ask the question more --
6 Because you haven't given a promotional speaking
7 engagement since that became an official separation
8 from that -- from CMEs, you have no basis to know
9 what is dictated or is not dictated in a promotional
10 speaking engagement in terms of content, correct?

11 A. That's true.

12 Q. So you would not know either, for example,
13 if the label is actually handed out to physicians,
14 correct?

15 A. I wouldn't know.

16 Q. And certainly if the label containing a
17 boxed warning like the language that we just read
18 for Duragesic was included in material, would you
19 agree that that will go towards presenting the
20 downside or the risks associated with the opioid for
21 the audience?

22 A. Yes.

23 MR. EHSAN: Now, I was told that 6:30
24 would be a good time for a break for you. So I'm at
25 a natural stopping point.

1 MS. SPENCER: If it's a natural stopping
2 point, because it's not an essential time, but if
3 it's a natural time it works for me.

4 MR. COLEMAN: We don't need to get to
5 essential.

6 MS. SPENCER: Fair enough.

7 MR. EHSAN: Why don't we take a break.

8 THE VIDEO OPERATOR: Off the record,
9 6:30.

10 (Recess at 6:30 p.m.,
11 resumed at 7:13 p.m.)

12 THE VIDEO OPERATOR: Back on the record,
13 7:13.

14 BY MR. EHSAN:

15 Q. Dr. Portenoy, I wanted to ask you a couple
16 more questions about just general treatment of
17 patients with chronic pain. Do you believe that in
18 your practice, chronic opioid use has helped some of
19 your patients who suffer from chronic noncancer
20 pain?

21 A. Yes.

22 Q. Has it helped some of them significantly?

23 A. Yes.

24 Q. Has it helped some of them significantly
25 over a period of time?

1 A. Yes.

2 Q. Do you believe that, knowing everything
3 that you know today, there are still patients who
4 are appropriate for long-term treatment with chronic
5 opioid therapy?

6 A. Yes.

7 Q. Including in a noncancer setting?

8 A. Yes.

9 Q. Do you have any examples you can think of
10 of a patient that's been a particular success story,
11 not providing names or specific --

12 MS. SPENCER: I was going to say --

13 (Court reporter interruption.)

14 BY MR. EHSAN:

15 Q. Do you have any examples in mind of a
16 patient who did not have -- who had chronic
17 noncancer pain who you recall received significant
18 benefit from chronic opioid therapy that you can
19 share without any of the specific identifying
20 details?

21 A. Yes. Well, I can share that the very small
22 practice I currently have that I mentioned before
23 consists of about 25 patients whom I've been
24 treating for between 15 and 20 years with opioids,
25 almost all of them with Schedule II opioids.

1 I have a patient, for example, who was
2 involved in a serious motor vehicle accident about
3 20 years ago, had multiple orthopedic injuries,
4 chronic deformity of her foot, and multiple sites of
5 pain, musculoskeletal pain related to the injury,
6 who, on opioid therapy, high-dose opioid therapy,
7 was able to be the president of her own company,
8 maintain a family life, essentially have a normal
9 life, and as a result of the opioid therapy, she
10 will tell you, and any effort to lower the dose of
11 the opioid immediately causes her pain to flare.

12 I have another patient who has a sort of
13 an -- he's a man in his 50s and he has an accelerated
14 problem of osteoporosis and degenerative spine
15 disease, which you see on MRI. And he has severe
16 pain in the neck, the back, and the arms. And he
17 has been on high dose opioid therapy for about
18 20 years. And he was never able to return to work
19 as an attorney. However, he has been able to live
20 with his family, to raise his family with his wife.
21 His wife works. He's been a stay-at-home dad, and
22 he has a good quality of life which he attributes
23 very emphatically to the fact that he continues to
24 have access to opioid drugs.

25 So all of these patients that I have are

1 of that ilk. People that I would swear benefit from
2 chronic opioid therapy at the doses that I've used
3 for them. And that periodically when I've tried to
4 lower the dose, get worse. They get more pain and
5 their function declines.

6 Q. So not only have some of your patients
7 received long-term pain relief from chronic opioid
8 use, but some of them have increased function as a
9 result of chronic opioid use, correct?

10 A. Right. There's no question about that.

11 Q. My understanding is your mother has been on
12 chronic opioid therapy -- now, I have an article in
13 case you find this to be intrusive that actually
14 talks about it, but --

15 A. I have my mother's permission.

16 Q. Okay. With that in mind, is it -- is my
17 understanding correct that your mother's been on
18 long-term chronic -- long-term opioid therapy for
19 chronic pain?

20 A. Yes.

21 Q. This is noncancer pain, correct?

22 A. Yes.

23 Q. And she has had success with it?

24 A. Yes. Oh, yes.

25 Q. And would you say that you are comfortable

1 with her taking chronic opioid therapy for her pain,
2 given the benefit she's received from it?

3 A. Oh, yes.

4 Q. And she's taking opioids for arthritis,
5 correct?

6 A. Yes.

7 Q. And as far as, at least the article
8 indicated, she has not had any indicia of abuse or
9 addiction, correct?

10 A. Correct.

11 Q. Now, if you look at patients -- or in your
12 experience patients who are undertreated or
13 inappropriately treated for severe pain, can they
14 suffer from depression?

15 A. Yes.

16 Q. Can they -- can they have problems holding
17 down a job?

18 A. Yes.

19 Q. Can they have problems with activities of
20 daily living?

21 A. Yes.

22 Q. Can they become essentially bedbound?

23 A. It's possible.

24 Q. Have you, in your experience, seen any
25 patients who began displaying aberrant behaviors

1 such as criminality when their pain wasn't
2 adequately treated?

3 A. I didn't hear the question.

4 Q. Sure. In your experience, have you
5 personally or have you heard of patients who have
6 displayed criminal behavior because their pain was
7 undertreated?

8 A. That's a complex question. Very rarely.
9 Really in the realm of two or three cases that I
10 recall, I've had patients engage in aberrant
11 behavior that I thought included diversion or
12 included such egregious aberrant behavior that it
13 crossed the line into criminality.

14 I could not tell you that that behavior
15 occurred because they had unrelieved pain. I think
16 they had pain. But I think attributing their
17 behavior to the pain is not possible to say. And so
18 I couldn't say yes to that.

19 Q. Are you aware of any -- either in your
20 practice or the practice of colleagues you're
21 familiar with any chronic pain patients who have
22 committed suicide from the chronic pain?

23 A. This has not been in my practice;
24 fortunately, I have not seen that. But I have heard
25 of that, yes.

1 Q. So not only -- and this was in a chronic
2 noncancer pain setting?

3 A. Yes.

4 Q. So it's not only a life and death situation
5 in terms of addiction and abuse, but it can be a
6 life and death situation in terms of treatment and
7 management of chronic pain as well, correct?

8 A. Yes.

9 Q. I think that goes to the gravity of the
10 physician's role in making a good decision for his
11 or her patient that you testified to earlier.

12 MR. BECKWORTH: Objection.

13 BY MR. EHSAN:

14 Q. Now, when you treat patients who have
15 chronic pain with opioids, those opioids have what's
16 called active pharmaceutical ingredients, correct?

17 A. Yes.

18 Q. And those active pharmaceutical ingredients
19 are either naturally derived from the poppy plant or
20 are synthetically manufactured, correct?

21 A. Yes.

22 Q. To the extent that they're natural opioids
23 from the poppy plant, do you have a sense of where
24 the active ingredients come from?

25 A. In terms of their manufacturer or . . .

1 Q. Yes.

2 A. Not in any specific way, no.

3 Q. Would it be fair to say you don't assume
4 that the United States is purchasing poppy plants
5 from Afghanistan, correct?

6 A. I wouldn't assume that, correct.

7 Q. Would it be fair to say you would want
8 whatever active pharmaceutical ingredient is
9 provided for the U.S. pharmaceutical industry to be
10 held to quality control measures and be in a way
11 that it can assure a supply to allow for
12 manufacturers to adequately meet the needs of
13 patients?

14 A. Yes.

15 MR. BECKWORTH: Objection.

16 BY MR. EHSAN:

17 Q. So there's nothing inherently wrong with
18 manufacturing the active pharmaceutical ingredient
19 for a drug, correct?

20 A. No.

21 Q. Even if that drug happens to be an opioid,
22 correct?

23 A. Correct.

24 Q. And if you didn't have the active
25 pharmaceutical ingredient, there would be no

1 opioids, correct?

2 A. Correct.

3 Q. Now, looking at the synthetic side of
4 things, are you aware that there has been an
5 increase in the manufacturing of fentanyl
6 derivatives outside of the United States that are
7 subsequently imported into the United States?

8 MR. BECKWORTH: Objection.

9 THE WITNESS: Yes, I'm aware of that.

10 BY MR. EHSAN:

11 Q. Let me break that question down. Are you
12 aware of illicit manufacturing of fentanyl in China?

13 A. Yes.

14 Q. Are you aware that significant amounts of
15 illicit fentanyl has been flooding the United States?

16 A. Yes.

17 Q. Are you aware that -- to what extent that
18 illicit fentanyl has contributed to deaths seen
19 associated with overdoses of opioids?

20 MR. BECKWORTH: Objection.

21 THE WITNESS: Yes. Yes, I believe --

22 BY MR. EHSAN:

23 Q. Go ahead. I'm sorry.

24 A. Yes, I believe the government has
25 attributed the continuing rise in opioid-related

1 mortality after 2011-2012 to mostly the fentanyl
2 products coming into the country.

3 Q. And would you agree that that illicitly
4 manufactured fentanyl, regardless of whether it's
5 China or somewhere else is not subject to the
6 control of the defendants in this case?

7 A. Yes, that's true.

8 Q. And its importation, illegal importation
9 into the United States, would be subject to
10 enforcement by certain U.S. governmental agencies,
11 correct?

12 A. Yes.

13 Q. You mentioned that we're having an opioid
14 crisis in the United States.

15 Do you recall that?

16 MS. SPENCER: Objection. I don't think
17 that was the witness's testimony.

18 THE WITNESS: I didn't -- I didn't use
19 the term "opioid crisis."

20 BY MR. EHSAN:

21 Q. What was the term you recall using?

22 A. Public health problem, public health issue.

23 Q. Focusing on that public health issue, is
24 that public health issue driven presently by the
25 death resulting from illicit fentanyl?

1 MR. BECKWORTH: Objection. It's
2 misleading. Counsel, you know that in Oklahoma
3 there's not a fentanyl problem.

4 MR. EHSAN: Again, I will move to strike.

5 MR. BECKWORTH: So will I.

6 MR. EHSAN: We can talk about it.

7 MR. BECKWORTH: You know the statistics.
8 You've deposed people in the article. It doesn't
9 exist.

10 BY MR. EHSAN:

11 Q. Dr. Portenoy, are you aware of any aspects
12 of the opioid problem or public health issue as it
13 particularly relates to Oklahoma?

14 MR. BECKWORTH: Objection.

15 BY MR. EHSAN:

16 Q. You can answer.

17 MS. SPENCER: He can answer if he --

18 THE WITNESS: No, I'm not aware of the
19 specifics in Oklahoma.

20 BY MR. EHSAN:

21 Q. So now let me ask you, are you aware of it
22 on a national level?

23 A. My knowledge of this is not deep. It mostly
24 comes from the media. But I have some information
25 about that.

1 Q. To the extent you have any knowledge, it's
2 not specific to Oklahoma, correct?

3 A. Correct.

4 Q. Would it be that to the extent you do have
5 any knowledge, it relates to the country as a whole?

6 A. Yes.

7 Q. Focusing on that public health issue that
8 you have some awareness of at a national level --

9 A. Right.

10 Q. -- do you believe that that public health
11 problem is presently being driven by the illicit --
12 by illicit fentanyl in the United States?

13 MR. BECKWORTH: Objection.

14 MS. SPENCER: You can answer to the
15 extent that you know.

16 THE WITNESS: My understanding now is
17 that that -- that the importing of illicit fentanyl
18 is part of the public health problem we now have,
19 particularly with respect to the continuing rise in
20 opioid mortality.

21 We continue to have a problem of
22 substance abuse and addiction, high rates of those
23 problems, as compared to the past with inadequate
24 access to substance abuse treatment. That problem
25 is not related specifically, as far as I know, to

1 the importation of fentanyl.

2 BY MR. EHSAN:

3 Q. Are we also seeing -- are you aware of any
4 uptick in the heroin abuse and mortality in the
5 United States?

6 A. I am, yes.

7 Q. And is it your understanding that the rates
8 of heroin abuse and mortality have also gone up?

9 A. Yes.

10 Q. This is all while prescription opioids have
11 actually decreased in terms of the total number of
12 scripts written, correct?

13 A. Yes. The total number of prescriptions
14 have declined, to my knowledge, since 2012. And the
15 opioid mortality related to prescription opioids
16 have declined since about 2011.

17 Q. I just want to ask you if you agree or
18 disagree with a couple of statements that I'm going
19 to present to you.

20 Do you believe that at any point you
21 spread misinformation or misleading information
22 related to any opioid therapy?

23 A. At the time that I discussed opioid therapy,
24 the information that I was providing, I believed to
25 be true and accurate.

1 I have expressed regrets about not
2 knowing then what I now know: that the opioid
3 problem was going to burgeon as it has and become a
4 public health problem at the level that it has.
5 Because if that was known, then the way that I would
6 have created messages about the risk element was --
7 would have changed.

8 In the early years, my focus in my
9 writings and my lecturing was more focused on trying
10 to destigmatize the opioids, trying to provide
11 information that I thought was accurate about the
12 known pharmacology, for example, with respect to
13 physical dependence and tolerance, and to discuss
14 how little we know about the addiction risk.

15 And to try to disabuse physicians of
16 some of the excessive concerns that they had that I
17 thought and still think led to undertreatment, even
18 in those populations where treatment was widely
19 considered to be appropriate, like cancer pain.

20 So the focus in those early years was on
21 trying to reduce that stigma by providing
22 information. The information I provided at the time
23 was true and accurate. But the focus of that -- of
24 those writings and that lecturing was more on the
25 destigmatization by presenting information as it

1 existed at that time.

2 What I have said publicly is that time
3 went forward and what we found out happened is that
4 the increasing access to opioids societally became
5 associated with the public health problem that we've
6 described today: increasing rates of addiction and
7 treatment-seeking for addiction, increasing rates of
8 abuse.

9 And most disquieting, increasing rates
10 of opioid mortality, which until 2011 was due to
11 prescription opioids. And had that -- had I known
12 in 1997, 2001, that that was going to happen, I
13 wouldn't have taught it in the same -- I wouldn't
14 have taught the information in the same way.

15 The last thing I'll just say is that the
16 necessity of messaging, creating information for
17 prescribers, teaching this in a way that balances
18 the risks and benefits for me personally was an
19 issue, even when I was focused more on trying to
20 destigmatize the drug.

21 For example, in the late '90s, I became
22 medical director of a pain and chemical dependency
23 conference, which was an international conference.
24 And over 10 years, we put on eight international
25 conferences. And we started a pain and chemical

1 dependency project, including a listserv, which was
2 international in scope.

3 Because we wanted to bring the addiction
4 medicine community and the pain community together
5 to help work out the appropriate way of teaching
6 this and provide information so that physicians
7 could balance risks and benefits in a more
8 knowledgeable way.

9 I know this is a long response, but it's
10 a complicated question. I don't think I ever
11 provided misleading information, no. But I think
12 that -- and I think that early on, I was one of the
13 people nationally who was talking about chemical
14 dependency and those issues: abuse, addiction, and
15 unintended overdose.

16 But I wish that I had known in the late
17 '90s and the early 2000s what I came to know later
18 in the 2000s, which was that we had a very
19 significant public health problem that occurred that
20 more than balanced the public health problem of
21 unrelieved pain, which is what you were alluding to
22 before, and which we still have today.

23 Had I known that we had that public
24 health problem related to addiction and abuse, if I
25 knew that that was going to occur, I think my

1 messages in my writings and my teaching would have
2 been somewhat different.

3 Just as accurate, but somewhat focused
4 on a broader perspective, including more information
5 about risk assessment and management than it did
6 back then.

7 Q. Did you happen to teach medical students
8 either presently or in the past?

9 A. No. I never taught medical students.

10 Q. How about residents?

11 A. Yes, of course.

12 Q. Now, when you were teaching residents, did
13 you focus them on making sure they understood the
14 prescribing information related to drugs they were
15 prescribing?

16 A. Yes.

17 Q. Do you believe that -- you, I think,
18 mentioned -- Strike that. I'm going to start over
19 again.

20 You had said, I think, on occasion had
21 championed discussions related to potential
22 addiction and abuse, correct?

23 A. In the sense of being the medical director
24 of the pain and chemical dependency project? Yes.

25 Q. And I believe in your declaration, you

1 state somewhere -- and, again, I don't have the
2 specific paragraph number -- but I'll speak in
3 general terms -- that you had applied to
4 pharmaceutical companies and had received some
5 monies from pharmaceutical companies to address the
6 addiction question; is that correct?

7 MS. SPENCER: I think that's
8 paragraph 26.

9 MR. EHSAN: Paragraph 26. Thank you.

10 THE WITNESS: Thank you.

11 MS. SPENCER: It starts on page 16, I
12 think. Yes.

13 THE WITNESS: I can answer?

14 MS. SPENCER: Yes.

15 THE WITNESS: Yes. The pharmaceutical
16 industry -- pharmaceutical companies, manufacturers
17 of opioids, supported the pain and chemical
18 dependency conferences that I put on.

19 BY MR. EHSAN:

20 Q. And you also mention in paragraph forty --
21 paragraph 46, I believe -- yes -- sorry to make you
22 jump around.

23 A. That's okay.

24 Q. -- paragraph 46 that you had communicated
25 on one occasion that you actually recollect, to

1 Janssen that the direct-to-consumer advertising
2 campaign that they presented to you was a bad idea,
3 correct?

4 A. Yes.

5 Q. And, in fact, in that instance, Janssen did
6 not follow through on that campaign, correct?

7 A. Correct.

8 Q. So you've had instances where you've raised
9 issues with the opioid manufacturers, and they, in
10 fact, have listened and taken your advice, correct?

11 A. I don't know whether or not they took my
12 advice. I only know that the program that was being
13 discussed with me didn't happen. So I'm not sure
14 why that didn't happen.

15 Q. And in the terms of the instances where you
16 requested money for programs, they gave you that
17 money, correct?

18 A. Yes.

19 Q. Likewise, when they sent you materials for
20 some of their educational programs, they asked you
21 to edit it, correct?

22 A. Yes.

23 Q. And obviously you are -- have more expertise
24 on the subject matter than perhaps someone within an
25 opioid manufacturing company, correct?

1 A. Yes.

2 MR. BECKWORTH: Objection.

3 MS. SPENCER: Objection. To the extent
4 that you know that.

5 THE WITNESS: To the extent that I know
6 that.

7 BY MR. EHSAN:

8 Q. Well, let me rephrase the question. You
9 are one of the world's leading experts on pain
10 management, correct?

11 A. Some people would consider me that, yes.

12 Q. Therefore, having you edit materials for
13 accuracy or to accurately reflect the literature
14 would not be surprising, correct?

15 A. I'm just not sure what you mean by "would
16 not be surprising."

17 Q. Sure. So it would not be unusual for
18 someone to ask you to review materials that relate
19 to your field of expertise, given you're a world
20 renowned expert in the area -- to ask for your
21 advice or your input on a particular piece of --
22 a particular document that has substantive material
23 in it, correct?

24 A. So if you're asking me if I would be
25 surprised that that would happen . . .

1 Q. So let me ask the question slightly
2 differently.

3 A. Yes, okay.

4 Q. To the extent that you had clinical
5 experience with patients and you understood the
6 literature, if you were going to, for example,
7 provide feedback on a piece of educational material
8 from a drug company, it would be perfectly
9 reasonable for them to ask you to comment on it,
10 correct?

11 A. In my opinion, yes, it would be reasonable
12 for someone who has drafted some education in an
13 area where I have a high level of expertise to get
14 my advice about whether or not what they've drafted
15 represents the best known science and practice.
16 That would be reasonable in my opinion.

17 MS. SPENCER: Just to be clear, my
18 objection was only to the inference that he had
19 personal knowledge of, you know, what sort of
20 experts may or may not exist within an opioid
21 manufacturing company.

22 MR. EHSAN: I can strike the question.
23 Let me just try again.

24 THE WITNESS: Okay.

25

1 BY MR. EHSAN:

2 Q. I just want to clarify a point that came
3 earlier. You mentioned that when you got --
4 sometimes when you got educational materials from
5 the pharmaceutical companies, you had to make
6 significant edits to them, correct?

7 A. Correct.

8 Q. Given that you have significant patient
9 experience, would it surprise you that you would be
10 in a position to perhaps add value to materials that
11 a pharmaceutical manufacturer of opioids is
12 preparing for doctor education?

13 A. It wouldn't surprise me that input from me
14 would be perceived as adding value to a piece of
15 education, given my experience in educating in this
16 area.

17 Q. That's all. It was not meant to create a
18 long, complicated process.

19 You were shown some documents about some
20 payments made to your school -- at the time, your
21 hospital, Beth Israel Medical Center, from -- by
22 Mr. Beckworth. And I just want to mark this next
23 item as an exhibit.

24 (Portenoy Exhibit 34 was marked
25 for identification.)

1 MS. SPENCER: Do we need to go back to
2 those or are we just moving on?

3 MR. EHSAN: We can if you'd like.
4 We can look at them.

5 MS. SPENCER: 12, 13, and 14?

6 MR. EHSAN: Yes.

7 MS. SPENCER: And this is 34? Do you
8 have one more for Brad?

9 THE WITNESS: Oh, I'm sorry. My
10 apologies.

11 MS. SPENCER: No problem. Thank you.

12 THE WITNESS: Do I need to look at the
13 prior material or not necessary?

14 BY MR. EHSAN:

15 Q. Not necessary.

16 A. Okay.

17 Q. This is an email string, and as you might
18 expect, goes backwards, most recent to the -- so the
19 original email is actually on the second page of the
20 document.

21 A. Um-hum.

22 Q. You see there's a Winifred Schein at
23 chpnet.org?

24 A. Yes.

25 Q. Emailing someone at -- or someone named

1 Robyn Kohn; do you see that?

2 A. Yes.

3 Q. And do you know who Winifred Schein is?

4 A. Yes. She still works with me and has been
5 with me for many years as the director of
6 development and institutional giving.

7 Q. And the email states, "Hi Robyn. I hope
8 all is going well for you. Per my voice message, I
9 am writing on behalf of Dr. Portenoy to invite you
10 to attend as our guest the DPMPC's conference for
11 nurses taking place on November 9 at Beth Israel.
12 This is entitled 'Emerging practices in pain
13 medicine and palliative care: Advances in nursing.'"

14 Do you see that?

15 A. Yes.

16 Q. And she attaches the agenda. And I believe
17 it says, "This is" -- "This also might be something
18 we could put on Quantia, and you may be interested
19 in sponsoring that."

20 Do you see that?

21 A. Yes.

22 Q. And if you look at Exhibits 12, 13, and 14,
23 you see that Quantia is the actual educational
24 program that generated the basis for the invoices or
25 the payments that were sent to you?

1 A. Yes, I --

2 Q. My question is simply, doctor, in your
3 experience, when you reached out to industry to help
4 support you in your educational endeavor, did you
5 find them to be accommodating?

6 A. Yes. During my 16 years at Beth Israel, we
7 put on a very large number of educational programs
8 for physicians and for nurses, programs on pain,
9 programs on palliative care. And we usually sought
10 industry financial support for these educational
11 programs.

12 And as you know from what we talked
13 about this morning, over the course of these many
14 years, my institution received large sums from
15 pharma companies, which I've been able to use to put
16 on these educational programs and create educational
17 materials.

18 Q. And were all these education programs on
19 just how to -- Strike that.

20 Were all these education programs
21 focused just on opioid therapy, or were they broader
22 than that?

23 A. They were broader than that.

24 Q. Did any of them focus on addiction?

25 A. Well, the pain and chemical dependency

1 conferences, which amounted, I believe, to eight
2 large conferences over ten years, were focused on
3 this interface between chronic pain and chemical
4 dependency. And typically more than half of that
5 two-and-a-half-day conference was focused on
6 addiction issues.

7 Q. How about issues of diversion?

8 A. At those conferences?

9 Q. Yes.

10 A. To my recollection, we invited speakers to
11 those conferences, individuals from law enforcement
12 that would help educate the audience, which the
13 audience comprised professionals, mostly physicians.

14 And the goal was to try to enhance
15 communication between law enforcement and physicians
16 so that physicians would understand what law
17 enforcement's expectations were with respect to
18 monitoring for diversion and what to do if it was to
19 occur, and reciprocally to try to educate people in
20 law enforcement about the medical community's issues
21 in trying to treat chronic pain.

22 Q. So would it be fair to say that the opioid
23 manufacturer provided you or your institutions
24 funding to facilitate education that directly went
25 to the risk associated with opioid prescribing?

1 MR. BECKWORTH: Objection.

2 MS. SPENCER: You can answer.

3 THE WITNESS: Yes. That's true.

4 BY MR. EHSAN:

5 Q. So that would be focusing on the negative
6 or the risk side of chronic opioid use, correct?

7 A. Yes.

8 Q. Now, doctor, we've gone through a whole lot
9 of science nerdy stuff, so I will try to distill
10 some of that down because sometimes I get into that
11 conversation and now it's just the two of us talking
12 and no one else understands what we're saying. But
13 maybe others do.

14 MR. BECKWORTH: Objection. Disrespectful
15 to the 12 people in the jury box.

16 BY MR. EHSAN:

17 Q. Doctor, would it be fair to say that at all
18 times, you provided the best possible and most
19 accurate information in your speaking -- Strike
20 that. Let me start more broadly.

21 You received money from opioid
22 manufacturers, correct?

23 A. Yes.

24 Q. It never influenced anything you said with
25 respect to saying something you didn't believe was

1 accurate, correct?

2 A. Correct.

3 Q. You also received funding for publications,
4 correct?

5 A. When you say "publications," you need to be
6 more specific.

7 Q. Sure. You received funding for studies,
8 correct?

9 A. Yes. Research studies.

10 Q. Research studies. And those fundings never
11 dictated to you anything about the conclusions or
12 your findings, correct?

13 A. That's correct.

14 Q. You gave a significant number of talks
15 related to opioid use; is that correct?

16 A. Yes.

17 Q. And in all of those talks, you tried to
18 present a fair and balanced presentation of the
19 science as we understood it at the time, correct?

20 A. Yes.

21 Q. Likewise, you never attended any speaking
22 engagement regardless of the context in which a
23 speaker provided information related to the use of
24 opioids that you did not find -- that you found to
25 be problematic or inappropriate or inaccurate,

1 correct?

2 A. I don't recall any.

3 Q. You have, in fact, given talks about
4 addiction, abuse, and diversion, correct?

5 A. I have given talks that have included
6 information about those areas, yes.

7 Q. Well, you have put on talks or conferences
8 that address abuse, addiction, and diversion,
9 correct?

10 A. Yes.

11 Q. And some of those talks were funded by
12 opioid manufacturers, correct?

13 A. Yes.

14 Q. As best as you recall, the labeling for
15 opioid medications included a section on the risks
16 and the benefits of the medication, correct?

17 A. Yes.

18 Q. And those included, at least in the 2000s
19 time period that we specifically talked about, a
20 discussion about addiction, diversion, and abuse,
21 correct?

22 A. Yes.

23 Q. And at least in the couple of instances
24 that you recalled, in a boxed warning, correct?

25 A. Yes.

1 Q. And as you testified, you encourage your
2 residents when you teach them to read the labeling
3 information for the medication they're prescribing,
4 correct?

5 A. No, I don't think I said that. When I
6 educate, whether it's residents or fellows, which is
7 a more common trainee level that I educate at --
8 these are people who have finished their residency
9 and getting extra training in pain medicine or in
10 palliative care, when I educate trainees or educate
11 colleagues, the emphasis is always on needing to
12 know what -- what -- needing to know the information
13 necessary to make judgments about what's safe and
14 effective for patients based on the specific
15 characteristics of the patient.

16 It hasn't been my practice to recommend
17 to everyone to read the package label. That has
18 never been an educational meme of mine, if you will.

19 However, including in my education
20 information about the pharmacology, how to optimize
21 the analgesic outcomes, what expectations should be
22 made for side effect monitoring and how to treat
23 side effects, and then to be aware of the risk of
24 abuse and addiction and in recent years how to
25 actually assess and manage that, that's always been

1 a part of what I've been teaching.

2 Q. Would you agree with me, doctor, that a
3 boxed warning on a prescribing information is the
4 FDA and the manufacturer's attempt to make sure that
5 certain key facets about either the risks or the
6 benefits of the medication are communicated to the
7 prescriber?

8 A. Yes. I think that's true.

9 Q. And I think you mentioned that as a
10 prescriber of a Schedule II, that prescriber should
11 take on the responsibility of being sufficiently
12 adept at knowing who to prescribe it to and how to
13 prescribe it?

14 A. Yes.

15 Q. We talked a lot about the individualized
16 decision that one has to make for a patient in
17 prescribing -- when deciding whether or not to
18 prescribe long-term opioids. And to the extent that
19 a doctor doesn't take on the responsibility of
20 knowing the risks and benefits of the medication,
21 is that -- Strike that. Let me ask the question
22 slightly differently.

23 Do you think that a prescriber who
24 doesn't understand or doesn't have the skills
25 necessary to prescribe an opioid bears some

1 responsibility for adverse effects that his or her
2 patients may suffer from those prescribing
3 decisions?

4 A. Yes. I think the physician has to bear
5 some responsibility, yes.

6 Q. Do you think that in some instances,
7 patients who are less than truthful with their
8 physicians bear some responsibility in potentially
9 exposing themselves to a higher risk of side effects
10 from opioid medications?

11 A. Yes. To the extent that occurs, that's the
12 patient's responsibility.

13 Q. Do you believe that pharmacy benefits
14 management companies or others who decide
15 formularies and those who put opioids on a preferred
16 formulary position bear some responsibility for
17 which patients get exposed to chronic opioid
18 therapy?

19 A. I don't have any specific information about
20 that. I am aware that the impact of these PBMs on
21 prescribing in the current era is -- can be very
22 onerous for physicians and can reduce choice for
23 patients and reduce choices for physicians.

24 At a hypothetical level, I can agree
25 with what you said, but I don't have any specific

1 information about that.

2 Q. Do you believe that insurance companies'
3 decisions to cover some pharmacological therapies
4 and not other nonpharmacological therapies can
5 contribute to opioid prescribing decisions by
6 physicians?

7 A. I do believe that that's true, yes.

8 Q. Do you believe that the federal government
9 could do more to protect the United States from
10 importation of illicit drugs?

11 A. That's asking me for expertise that I
12 really don't have. As a citizen, I would say yes.
13 But I don't have any specific knowledge about what's
14 being done and what could be done.

15 Q. Just to be clear, I think based on your
16 declaration, you're here just to testify on things
17 you know. And so it's your personal opinion. And
18 so to that extent, please share it. I will take it
19 as nothing else.

20 MR. BECKWORTH: Objection. That's
21 inappropriate.

22 BY MR. EHSAN:

23 Q. So, I'm sorry, please answer the question
24 again.

25 MS. SPENCER: Can you ask the question

1 again.

2 MR. EHSAN: Sure.

3 BY MR. EHSAN:

4 Q. Do you believe, as Dr. Portenoy, that the
5 government could do more to stem the tide of illicit
6 drug smuggling into the United States?

7 MR. BECKWORTH: And objection. He said
8 he doesn't know about that. And I just want to be
9 clear, you're asking him to speculate in an answer
10 that he told you he was not qualified to give?

11 I just want to be clear that that's what you're --

12 MR. EHSAN: I don't think that's what he
13 said. I can't say -- he's saying as a citizen,
14 that's what I would expect my government to do.

15 MS. SPENCER: Let me just say, he can
16 answer to the extent that he knows.

17 MR. EHSAN: Right.

18 BY MR. EHSAN:

19 Q. To the extent that you have a personal
20 opinion about this.

21 A. Right. So --

22 Q. If you have none, you can say you have no
23 opinion on the matter.

24 A. I have an opinion. And, again, it's an
25 opinion that's not informed by a lot of facts about

1 how the government does this. But we have a very
2 significant problem of importation of very highly
3 potent opioids. And those are particularly
4 dangerous.

5 And I would expect the government to do
6 more to try to reduce the availability of those
7 highly potent opioids like fentanyl and now
8 carfentanil coming into the country, which are so
9 risky to people.

10 Q. To the extent that there is a shortage of
11 addiction medicine specialists in the United States,
12 do you think that has contributed to the public
13 health problem we're discussing today?

14 A. Yes. Not only the lack of specialists.
15 The lack of specialists is one component of the
16 insufficient access to substance abuse treatment in
17 the United States.

18 The United States historically has not
19 provided adequate funding for substance abuse
20 treatment of all its many types, including access to
21 specialists. And that is a significant problem that
22 should be addressed.

23 Q. Likewise, is insurance or lack thereof for
24 substance abuse treatment a potentially contributing
25 factor to the public health crisis we're talking

1 about today?

2 A. Again, I have no specific knowledge of the
3 extent to which that impacts on access to substance
4 abuse treatment. But to the extent that it does,
5 that would be a significant problem.

6 Q. So if you're looking at the big picture,
7 I think Mr. Beckworth asked you, you know, whether
8 it was the pharmaceutical industry or the opioid
9 manufacturers at fault.

10 Would it be fair to say that every facet
11 of society from the patient all the way up to the
12 federal government could have done things
13 differently, which may or may not have had an impact
14 of where we are today with this public health
15 crisis?

16 MR. BECKWORTH: Objection.

17 MS. SPENCER: I'm going to object to the
18 term "every facet of society" and ask you to be more
19 specific.

20 MR. EHSAN: Sure.

21 MS. SPENCER: I get from -- you know,
22 from the patient all the way up to the federal
23 government, but "every facet of society" I think is
24 too broad for him to answer.

25 MR. EHSAN: Sure.

1 MR. BECKWORTH: I agree. I feel like
2 I'm a facet of society. So I object. And the
3 jury's a facet of society, so I object to that as
4 well on their behalf.

5 BY MR. EHSAN:

6 Q. From patients, prescribers, insurers,
7 PBMs, health care authorities, Food and Drug
8 Administration, drug enforcement agency, specialty
9 training practices and education generally, would
10 you agree that there are lots of folks who have
11 played some part in where we are in this health care
12 crisis?

13 MR. BECKWORTH: Objection.

14 MS. SPENCER: It's compound.

15 MR. EHSAN: Sure. Let me ask the
16 question again.

17 BY MR. EHSAN:

18 Q. You can answer if you understand the
19 question.

20 THE WITNESS: Okay.

21 MS. SPENCER: You can answer if you
22 understand.

23 THE WITNESS: I think I understand the
24 question. And I'm agreeing with the question. I
25 think the public health problem that has emerged of

1 this rapidly increasing rate of opioid toxicity and
2 abuse and addiction is a multifaceted problem with
3 complex causes and multiple complex possible
4 solutions.

5 And attributing some effect of these
6 various entities -- the FDA response, the public's
7 response, the prescriber's response, the payer's
8 response, the PBM response -- to me is fair because
9 we could all look back and say, What could be done
10 differently.

11 Just as I myself, speaking for myself as
12 an academician, who's been an educator and an
13 investigator in this area, looks back and says, Had
14 I known then what I know now, the way I taught this
15 would have been different.

16 So I think it's fair to say that it's a
17 complex multifaceted problem with many potential
18 inputs that drove the ultimate outcomes that we're
19 dealing with today.

20 And as you know from my testimony this
21 morning, I've come to believe that one of those
22 facets is the pharmaceutical companies' use or
23 distillation of very positive messages without
24 providing context and information about risk and
25 using those messages in marketing strategies that

1 drove -- to some extent, drove prescriber behavior
2 such that patients who shouldn't have had access got
3 access to opioid drugs and physicians who didn't
4 have the skill set were prescribing, and patients
5 were not appropriately monitored after they got the
6 drug. And to some extent, responsibility, in my
7 opinion, is there as well.

8 BY MR. EHSAN:

9 Q. And, doctor, just so that I'm clear, are
10 you aware of any specific example of any particular
11 prescriber being unduly influenced to prescribe an
12 inappropriate prescription for an opioid based on
13 the materials you were just talking about?

14 MR. BECKWORTH: Objection.

15 MS. SPENCER: You can answer.

16 THE WITNESS: I'm not aware. No, I
17 can't point to an individual case of a prescriber
18 that prescribed inappropriately and I knew that that
19 happened as a result of inappropriate marketing.
20 No, I can't do that.

21 MR. EHSAN: Thank you.

22 MR. COLEMAN: If we want to take a four-
23 minute break, I think organizationally it would be
24 very helpful. And then we can wrap up.

25 MR. EHSAN: I think I'm done with my

1 questioning, doctor, so I was going to pass the
2 witness just so that they're more efficient and we
3 swap seats if that's okay.

4 THE WITNESS: I see.

5 MR. BECKWORTH: Should we stay here?

6 THE VIDEO OPERATOR: 7:55, off.

7 (Recess at 7:55 p.m.,
8 resumed at 8:14 p.m.)

9 THE VIDEO OPERATOR: We're back on, 8:14.

10 (Portenoy Exhibit 35 was marked
11 for identification.)

12 BY MR. EHSAN:

13 Q. Dr. Portenoy, I'm going to hand you what's
14 been marked as Exhibit 35. First I'll ask if you
15 need to take a moment to look at this. But then my
16 question is, do you recognize this document?

17 A. I just need a moment.

18 Q. Sure.

19 A. I don't remember this particular document.

20 Q. I will represent to you, doctor, that this
21 is a motion or memorandum of law in support of your
22 motion to dismiss you as a defendant in a lawsuit
23 filed in the State of New York. And as you can see
24 here, it was authored by your counsel, Ms. Spencer.

25 A. Yes.

1 Q. Before I get to two specific questions I
2 have on it, did you at any point review this
3 document before it was filed with the court, or do
4 you have any recollection of reviewing it before it
5 was filed with the court?

6 A. I don't have any recollection of reviewing
7 it before it was filed.

8 Q. If you go to the page that -- well, it's
9 got two paginations, but 14 of 26.

10 If you look at the last paragraph on
11 that page, this states, "In addition, as set out in
12 the JMTD" -- and I'll skip some legalese language
13 there -- "the complaint does not and cannot as a
14 matter of law allege facts showing how any of the
15 unbranded materials are deceptive or misleading and
16 viewed, as they must be, in the light of the
17 totality of information available to the person
18 allegedly misled, here, the county."

19 Do you see that doctor?

20 A. Yes.

21 MR. BECKWORTH: Objection.

22 BY MR. EHSAN:

23 Q. Would you agree with me that if you are
24 going to consider certain unbranded material as
25 deceptive or misleading, that you would first have

1 to look at it in the context of the totality of the
2 information available?

3 MR. BECKWORTH: Objection.

4 MS. SPENCER: You can answer. If you
5 understand the question.

6 THE WITNESS: I don't really understand
7 the question. I'm sorry.

8 BY MR. EHSAN:

9 Q. That's okay. So the point here is that in
10 order to -- for any unbranded material, i.e.,
11 opioids, can be used to treat pain, to be deceptive
12 or misleading, it has to be viewed in the context of
13 all available information, for example, the label,
14 the REMS, the FDA publications, the DEA, the
15 literature, et cetera.

16 Do you agree with that proposition?

17 A. Yes. I think at a high level, I would
18 agree with that, sure.

19 Q. Then it goes on to say, "This is especially
20 so when they are considered through the lens of the
21 'informed intermediary doctrine,' and then New York
22 and federal laws governing expectations of physicians
23 prescribing opioids, as they also must be."

24 Do you see that?

25 A. Yes.

1 MR. BECKWORTH: Objection.

2 BY MR. EHSAN:

3 Q. Do you know what an informed intermediary
4 is?

5 A. No.

6 Q. Do you understand that for something to
7 be -- well, for a prescription to be written, it has
8 to be done by a physician, correct -- or a licensed
9 health care professional, correct?

10 A. Correct.

11 Q. And that person is considered an informed
12 intermediary, i.e., someone who's educated and then
13 makes a decision --

14 MS. SPENCER: I'll object to the extent
15 that you're asking him to -- this -- we all know
16 "informed intermediary" is a legal term. So I'll
17 object to the extent that you're asking him to
18 describe to the 12 of us sitting in the room the
19 legal term because he's not a legal expert.

20 MR. EHSAN: Sure. I'm not asking --

21 MS. SPENCER: I understand but I just
22 needed to put on the record that, you know, he can't
23 explain to you the legal term.

24 BY MR. EHSAN:

25 Q. But the idea is that whether or not some

1 unbranded materials may contain misinformation has
2 to also be considered in the prism that is being
3 provided to someone who is a prescriber of the
4 medication at issue, correct?

5 A. Correct.

6 Q. And that person has certain training,
7 education, background, and expertise, correct?

8 A. Yes.

9 Q. And if you go to the next page, which is
10 page 11, on the document, or 15 of 26, you'll see in
11 the big paragraph there's a long string cite with
12 lots of numbers, and I'm picking up with the
13 sentence that follows:

14 "These articles provide further context
15 for the statements in unbranded publications that do
16 nothing more than permissibly express matters of
17 medical opinion or put the medications in the best
18 possible light, as the pharmaceutical and physician
19 defendants are entitled to do."

20 Do you see that?

21 A. Yes.

22 Q. Would you agree that a pharmaceutical
23 company has the right to put its medication in the
24 best possible light?

25 A. Let me just ask you to clarify that question

1 again.

2 Q. Sure.

3 A. I'm not sure what you mean by "best
4 possible light."

5 Q. Sure. So as a manufacturer of any
6 pharmaceutical, the manufacturer is subject to
7 certain FDA regulations, correct?

8 A. Correct.

9 Q. As a manufacturer of a controlled substance,
10 a manufacturer is also subject to DEA regulations,
11 correct?

12 A. Correct.

13 Q. So those are regulatory agencies that
14 provide information. Within that framework, do you
15 agree that a manufacturer can put its product in a
16 light that's -- well, strike that -- the best
17 possible light as stated in the motion that your
18 counsel filed?

19 MR. BECKWORTH: Objection. Did you
20 strike your entire question or just the last part?

21 MR. EHSAN: Just the last portion.

22 MR. BECKWORTH: Objection.

23 MS. SPENCER: You can answer if you
24 know.

25 THE WITNESS: Yeah. So I don't -- I

1 don't know. So I really can't answer specifically.
2 I'm still not clear about what "the best possible
3 light" means in this context.

4 BY MR. EHSAN:

5 Q. And you understand that this motion to
6 dismiss was filed on your behalf by your attorney?

7 A. Yes.

8 Q. And this was your motion in response to a
9 lawsuit that made allegations that you put certain
10 opioid medications in a light that was more
11 favorable than it should have been?

12 MS. SPENCER: To be clear, objection.
13 Not this lawsuit.

14 MR. EHSAN: No. A lawsuit filed in the
15 State of New York.

16 MS. SPENCER: Objection too. That's
17 a -- I mean, I don't recall that that was the exact
18 allegations. But if, you know, you'll accept that
19 that's a generalization of what was alleged, I'll
20 let him answer.

21 BY MR. EHSAN:

22 Q. At a high level, doctor. That was not a
23 verbatim recitation of the complaint.

24 MR. BECKWORTH: Objection.

25 THE WITNESS: Okay. At a high level,

1 yes.

2 BY MR. EHSAN:

3 Q. So let me ask the question over again. And
4 you understand that this motion was in response to a
5 lawsuit in New York that, generally speaking, made
6 allegations that you, Dr. Portenoy, made statements
7 about opioids that put them in a better light than
8 should have otherwise done?

9 A. Yes.

10 MR. BECKWORTH: Objection.

11 MR. EHSAN: I think that's all I have.
12 I'm going to pass the mic to my colleague here.

13 MR. ERCOLE: Sure.

14 MR. EHSAN: Thank you so much for your
15 time, doctor.

16 MR. COLEMAN: I think I'll change seats
17 with you just to make it a little bit easier.

18 EXAMINATION

19 BY MR. COLEMAN:

20 Q. Good evening. I'm Hayden Coleman. We had
21 met a little bit earlier, but I'll reintroduce
22 myself.

23 I'm going to direct your attention to
24 what was marked as Exhibit 17. And we might as well
25 pull Exhibit 18 because they're related. These were

1 exhibits that the State showed you earlier in the
2 deposition.

3 A. Yes.

4 Q. So this -- Dr. Portenoy, the first letter,
5 Exhibit 17 is dated February 27, 1997; is that
6 correct?

7 A. Yes.

8 Q. And that was sent to you when you were at
9 Memorial Sloan-Kettering?

10 A. Exhibit 17?

11 Q. Yes, Exhibit 17.

12 A. So this is a letter that I sent.

13 Q. Oh, I'm sorry. This is a letter that you
14 sent when you were at Memorial Sloan-Kettering. And
15 it seems to be responding to a request that you come
16 up and speak at Reading Hospital in West Reading,
17 Pennsylvania?

18 A. Yes.

19 Q. Where is West Reading, Pennsylvania?

20 A. I couldn't tell you.

21 Q. And we're talking about a speech that was
22 planned nearly a year in advance.

23 A. Yes.

24 Q. So this seems to be kind of a large event
25 for them at the hospital, would you agree with that?

1 A. I'm sorry. I just have no recollection of
2 it at all.

3 Q. Well, let's go to the document and see if
4 this refreshes your recollection a bit. It says,
5 "I apologize for the delay in responding to your
6 kind invitation . . . to speak at your hospital in
7 1998. I would be pleased to accept your invitation
8 to make the presentation on Tuesday, April 28 and
9 Wednesday, April 29. The topic you have asked me to
10 speak" -- "The topics you have asked me to speak on
11 are fine with me. I will let you know the title of
12 my presentation to your tumor conference as the time
13 approaches."

14 Did I read that correctly?

15 A. Yes.

16 Q. So the invitation is coming from the
17 Reading Hospital; is that correct?

18 A. Yes.

19 Q. And the subjects are being chosen by the
20 Reading Hospital?

21 A. They were suggested, according to the
22 letter.

23 Q. Right. They suggested and they are fine
24 with you?

25 A. And they were fine with me.

1 Q. So no pharmaceutical manufacturer
2 whatsoever had anything to do with the selection of
3 these topics --

4 A. That would be correct.

5 Q. -- is that --

6 That would be correct. So the letter
7 continues that [as read], My honorarium for the
8 two-day visit is \$2,500 plus expenses. I am a
9 member of the Purdue Frederick, Roxane, and Janssen
10 Speakers' Bureau; perhaps you would like to solicit
11 funding from them.

12 So let's go to the next exhibit, which
13 is 18. So on March 18, 1998, there is a letter from
14 Jennifer Henway [sic]. Are you familiar with
15 Jennifer Henway?

16 A. No.

17 Q. Henry, sorry. Are you familiar with
18 Jennifer Henry?

19 A. No. I don't have any recollection of her.

20 Q. But she's at The Purdue Frederick Company.

21 A. Right.

22 Q. And her title seems to be coordinator of
23 medical education?

24 A. Right.

25 Q. And apparently they're sending a check for

1 \$2,500. Are there any conditions or strings
2 attached to this?

3 A. Again, I don't have a specific recollection
4 of this conference in 1998.

5 Q. Right.

6 A. But in general --

7 Q. Right.

8 A. -- my recollection is that conferences like
9 this would have no strings attached at all --

10 Q. Right.

11 A. -- from the perspective of the pharma
12 company.

13 Q. It seems to have absolutely no involvement
14 other than paying for the honorarium?

15 A. Correct.

16 Q. And the topics of this conference is --
17 seem to be giving three distinct lectures. And the
18 first one is "cancer pain syndromes"?

19 A. Yes.

20 Q. And that's -- the next one is "cancer pain
21 management." And that's the tumor conference?

22 A. Yes.

23 Q. Is that correct?

24 A. Yes.

25 Q. Would you assume that most of the people at

1 a tumor conference are oncologists --

2 A. Yes.

3 MR. BECKWORTH: Object.

4 BY MR. COLEMAN:

5 Q. -- or people that work in the oncology
6 field?

7 A. Yes.

8 Q. And the next one is "medical grand rounds."

9 Would you explain what medical grand rounds are.

10 A. It's a traditional education forum, most
11 hospitals, most medical schools have a grand rounds.
12 It's typically a conference in a lecture hall --

13 Q. Right.

14 A. -- on a regular basis, once a month, once a
15 week, with -- sometimes with an outside speaker.

16 Q. Right. So this was one of those times?

17 A. This was one of those times.

18 Q. And this was planned a year in advance?

19 A. Right.

20 Q. So I know you have no specific
21 recollection, but it would seem that this is an
22 event for the Reading Hospital in Reading,
23 Pennsylvania.

24 Would you agree with that?

25 A. Yes. I think a two-day -- a two-day

1 arrangement like this would often be framed as a
2 visiting professorship.

3 Q. Right.

4 A. And I don't know if that got discussed.

5 But just speaking in general, if an expert is asked
6 to visit a hospital, particularly a hospital that
7 may be in a smaller -- a smaller hospital in a more
8 rural area --

9 Q. Right.

10 A. -- that doesn't have access to a lot of
11 outside speakers with expertise or national
12 reputations, they may make an effort to have a
13 two-day visit, call it something like a visiting
14 professorship, and then ask that person to give
15 multiple talks. And this seems -- again, I'm sorry
16 that I don't have a recollection about it --

17 Q. Right.

18 A. -- it's a long time ago. But this seems to
19 be of that type.

20 Q. So -- and you were at Sloan-Kettering at
21 the time?

22 A. Yes.

23 Q. And Sloan-Kettering is certainly one of, if
24 not the leading cancer center?

25 A. Yes.

1 Q. And you were being asked to speak to at
2 least one group of oncologists to talk to them about
3 cancer pain management. So this --

4 A. Yes.

5 Q. -- this is significant in that it has the
6 ability to really affect patient care in a somewhat
7 rural community; would you agree with that?

8 MR. BECKWORTH: Objection.

9 MS. SPENCER: To the extent that you
10 know or recall, you can answer.

11 THE WITNESS: So I think -- I think --

12 BY MR. COLEMAN:

13 Q. Let me rephrase the question.

14 A. Yes. Right.

15 Q. This is consistent with what you talked
16 about earlier as your educational purpose in being
17 able to talk to other medical professionals and
18 inform them of what you've been doing and learning;
19 is that a fair statement?

20 A. That's a very fair statement. I would
21 travel to places like this during that part of my
22 career with the hope of improving medical practice
23 with respect to pain management. That was what I --
24 how I perceived my professional role.

25 Q. Right.

1 A. To be a resource. Because I did spend time
2 studying this material. And I'm talking also about
3 cancer pain and cancer pain syndromes. My expertise
4 in pain was not just about opioids and nonmalignant
5 pain. It was about chronic pain in general,
6 including cancer pain and palliative care, which,
7 again, palliative care was just a blip on the radar
8 then. So I would do these talks in the hope that I
9 would change practice.

10 Q. So this is, to be colloquial, right in your
11 sweet spot?

12 A. Yes.

13 Q. And you would have gone and, based your
14 testimony earlier, it would have been your
15 presentation; it would have -- is that correct?

16 A. Yes, that's correct.

17 Q. It would have been as fair and balanced as
18 the literature and the science provided in March 18
19 of 19 -- or April 28 of 1998?

20 A. Yes.

21 Q. And there was certainly nothing promotional
22 about this -- this symposium; is that correct?

23 A. Although I have no specific recollection --

24 Q. It doesn't seem to be?

25 A. -- it doesn't seem to be. And I would

1 agree with that.

2 Q. So, again, Purdue was asked to sponsor it,
3 and they did, and that was the total involvement?

4 A. Yes.

5 Q. You testified earlier that after Sloan-
6 Kettering, you were -- you took a position as the --
7 I want to get this right -- chairman in new
8 Department of Pain Management and Palliative Care at
9 what at that point was Beth Israel?

10 A. Yes. I was asked to found the country's
11 first department devoted either to pain or
12 palliative care in an academic medical center.
13 It was the country's first department.

14 MR. COLEMAN: Right. So I'm going to
15 mark this -- I don't know what exhibit we're up to.

16 MS. SPENCER: 36. Is that right?

17 (Portenoy Exhibit 36 was marked
18 for identification.)

19 BY MR. COLEMAN:

20 Q. So I'll give you time to review this
21 because I . . .

22 So could you explain --

23 MS. SPENCER: Just one moment so I can
24 look at it.

25 MR. COLEMAN: Oh, sorry.

1 THE WITNESS: Yes.

2 BY MR. COLEMAN:

3 Q. So would you describe what this letter is.

4 A. So this was a fund-raising letter that I
5 wrote on assuming my new position as the chairman of
6 the Department of Pain Medicine and Palliative Care.

7 As I said in the letter, that department
8 had very ambitious goals. It included a pain
9 division, a division of chronic pain and acute pain,
10 a palliative care division, and also an institute
11 for education and research, the mission of which was
12 to conduct educational programs and also to do
13 research.

14 And my arrangement with the hospital
15 provided me with some seed money for the goals of
16 the department. So I had access to some dollars to
17 bring people with me to this -- to this new
18 department, people who would do research and who
19 would help me do programs.

20 But my charge as chair was to acquire
21 funding to support our academic mission.

22 Q. Right.

23 A. And this was a letter -- I believe that I
24 sent a letter like this to a variety of potential
25 industry partners, people who -- companies that had

1 supported educational programming in my area of
2 interest, to determine whether or not they would be
3 open to providing unrestricted support for
4 infrastructure, staffing, and early program
5 development so that I could get the department off
6 the ground.

7 Q. Can you explain what you mean by
8 "unrestricted support."

9 A. Yes. This would be -- the request of this
10 letter would be for funds that would be for general
11 support of the mission of the organization, of the
12 departments.

13 So there would be no specific link to a
14 requirement to put on this conference or to do this
15 piece of research or to develop a specific program.
16 It would be up to -- up to me about how to use that
17 money to support the mission of the organization.

18 Q. Right. So -- and looking at the letter for
19 a moment, it says, "Dear Dr. Lazarus." And you
20 crossed that out and you said "Harry."

21 That's usually something that you do
22 when you're familiar with somebody and you don't
23 want to be too formal; is that correct?

24 A. Yes.

25 Q. And who was Harry?

1 A. So I actually don't recall his -- his title
2 or what specific job he had. But he interacted with
3 the academic community.

4 Q. Right. So this was somebody that you knew
5 beforehand --

6 A. Yes.

7 Q. -- and had a business relationship with or
8 professional relationship with?

9 A. Yes. You know, he was the person at Purdue
10 Frederick who could be contacted to discuss the
11 potential for support for academic -- academic
12 programs or research programs.

13 Q. Right. And the request here is "Would
14 Purdue Frederick consider a request for \$100,000 per
15 year for each of the next two years to provide our
16 institute" -- I'm sorry. I'm reading on page 2, the
17 second-from-the-last paragraph -- "for the next two
18 years to provide our institute with seed monies for
19 a broad-based educational program in pain and
20 palliative care?"

21 So that's the unrestricted grant that
22 you were just explaining to us --

23 A. Yes.

24 Q. -- is that correct?

25 A. That's correct.

1 Q. Do you recall if Purdue gave the grant?

2 A. When I started the department, I asked for
3 this kind of support from several potential
4 partners. And we did receive some support. But I
5 can't recall whether or not Purdue Frederick was one
6 of those partners.

7 Q. Right.

8 A. Perhaps you have documentation that . . .

9 Q. Well, we do know -- I'm not going to get
10 through it, but we do know from our earlier exhibits
11 that the State showed us that there was support from
12 Purdue in the form of unrestricted grants.

13 A. Right.

14 MR. COLEMAN: So I don't think we have
15 to dwell on that.

16 The next -- I'm going to mark this for
17 the next exhibit.

18 MS. SPENCER: For the record, I recognize
19 that, you know, Dr. Portenoy adopted the crossing
20 out of "Dr. Lazarus" and wrote "Harry." It's not
21 clear to me -- there are other handwritten notes on
22 this document.

23 MR. COLEMAN: Well, I'll go through
24 that. I'm glad you mentioned that. If you hand
25 that back to him.

1 BY MR. COLEMAN:

2 Q. If you look under the signature, under your
3 signature --

4 A. Yes.

5 Q. -- do you recognize that handwriting?

6 A. Yes. That's me.

7 Q. And because you're a doctor, I'll ask you
8 to read it.

9 A. It says, "Harry, Thanks for considering
10 this. Russ."

11 Q. So I would assume that the cross-out is in
12 the same handwriting as well?

13 A. Yes.

14 Q. So that is you?

15 A. That is me.

16 MR. COLEMAN: Okay. Thank you.

17 MS. SPENCER: That wasn't the one I was
18 referring to. Maybe I have a draft that someone
19 else -- I have a little equal sign by the second
20 paragraph. I have a little note by the second-to-
21 last paragraph. And I have some notes on the first
22 page above and below the "received."

23 MR. COLEMAN: I think we can ignore
24 those. I'm not making anything --

25 MS. SPENCER: You don't represent that

1 they're his?

2 MR. COLEMAN: No, not at all. I think
3 those may just be stray marks on the document. So
4 thank you for clarifying all of that.

5 MS. SPENCER: Thank you.

6 MR. COLEMAN: Can we mark this exhibit.
7 (Portenoy Exhibit 37 was marked
8 for identification.)

9 BY MR. COLEMAN:

10 Q. Marking as Exhibit No. 37 --

11 MS. SPENCER: Thank you. Just one
12 moment. If he and I can take a moment.

13 MR. COLEMAN: Absolutely. I'm sorry.

14 I'm rushing because we're charged --

15 MS. SPENCER: I understand completely.
16 I just want to make sure that everyone is clear and,
17 you know, we do this carefully and appropriately on
18 all of our parts.

19 MR. BECKWORTH: She made me wait too.
20 It's painful.

21 MS. SPENCER: I made you wait longer.

22 MR. BECKWORTH: You did.

23 MR. COLEMAN: I'm showing him much
24 shorter documents.

25 MS. SPENCER: True. All true. Okay.

1 BY MR. COLEMAN:

2 Q. So, Dr. Portenoy, I believe I heard you
3 testify earlier about a worldwide pain conference
4 that you were, I felt, very enthusiastic about
5 being -- about helping organize; is that correct?

6 MS. SPENCER: Object. I don't recall
7 that he was excited about that --

8 BY MR. COLEMAN:

9 Q. Did you testify that you were on the board
10 of a worldwide pain conference?

11 A. I think that what I testified to before is
12 that I was one of the organizers and the medical
13 director of a pain and chemical dependency
14 conference, a series of those conferences, which
15 were international.

16 Q. So is that the same or different from this
17 worldwide pain conference?

18 A. This is entirely different.

19 Q. Completely different?

20 A. Right.

21 Q. So this was -- this was another conference
22 that you were going to be attending and speaking at;
23 is that correct?

24 A. Yes.

25 Q. And Purdue provided an honorarium for you

1 to do this?

2 A. Yes.

3 Q. Is that what the letter suggests?

4 A. Yes.

5 Q. And this is in the year 2000?

6 A. Yes.

7 Q. And when you attended that conference, you

8 would have provided the best medical information

9 that you had available in the year 2000 --

10 A. Yes.

11 Q. -- is that correct?

12 A. Yes.

13 Q. And it would have been as factually and

14 medically accurate as it could have been based on

15 that?

16 A. That's true.

17 MR. COLEMAN: Okay, thank you. No more

18 questions on that document.

19 I'll mark this document as 38.

20 (Portenoy Exhibit 38 was marked

21 for identification.)

22 MR. COLEMAN: So are you ready --

23 THE WITNESS: I am.

24 MR. COLEMAN: Amy?

25 MS. SPENCER: Yeah, he can go ahead.

1 BY MR. COLEMAN:

2 Q. So can you give context to this letter?

3 A. Yes. By 2001, I was participating with a
4 group of people on this project that we called the
5 project on pain and chemical dependency. And it
6 consisted of an annual or a biannual international
7 conference which we put on in New York in most years
8 and one year we put on in Washington. It also
9 included a listserv.

10 And it created a membership organization
11 for a short time, an international membership
12 organization that we called the International
13 Association for Pain and Chemical Dependency, which
14 was overseen initially by an Australian physician
15 who was involved in pain and chemical dependency.

16 So there was a fairly significant
17 commitment on my part to do programming, educational
18 programming on this, what we called the interface
19 between pain medicine and chemical dependency.
20 Really the issues related to addiction and abuse as
21 it relates to the therapeutic use of opioids.

22 In 2001, some colleagues expressed
23 interest in possibly joining my department and
24 creating a more formal subunit devoted to that
25 issue. And I became very excited about the

1 possibility of having this created in my department.
2 I thought that if I had this critical mass of
3 experts in my department working with the people who
4 are already there, we could really accomplish a lot
5 in this area.

6 And I needed, however, external funding
7 to bring these people in and pay their salaries.
8 This was not something that I could create a
9 business plan for, for the hospital nor would the
10 hospital support it.

11 So the thought was that we would go to
12 multiple opioid manufacturers in the same way that I
13 went to multiple opioid manufacturers when I started
14 my department. And we would see whether or not the
15 opioid manufacturers wanted to come together as a
16 consortium to support this not-for-profit entity in
17 my department that would try to further the goal of
18 educating and doing program development on this
19 issue of pain and chemical dependency.

20 That's what the context is in this
21 letter. And I reached out to Dr. Goldenheim at
22 Purdue to determine whether there might be interest
23 in providing support for that.

24 Q. So is this also considered an unrestricted
25 grant --

1 A. When we asked --

2 Q. -- what you were asking for?

3 A. Yes. So it was conceptualized as a
4 completely unrestricted grant to support the
5 infrastructure cost and the startup cost of this new
6 entity.

7 Q. Right. So what we're looking at is your
8 kind of written explanation from you to Paul
9 Goldenheim to help get this project up and running --

10 A. That's right.

11 Q. -- is that a fair interpretation of what
12 you said?

13 A. That's right.

14 Q. Were you able to do this?

15 A. No. After we made an attempt to get
16 funding from various sources, it didn't materialize
17 and the project was dropped.

18 Q. No further questions on this document.

19 Dr. Portenoy, you had testified earlier
20 in going through your declaration -- and I'm going
21 to ask some questions on the declaration --

22 MS. SPENCER: I'll just ask the same
23 thing that I ask of everybody else, if you could
24 kind of let us know what the paragraph is. And if
25 you're not sure, I do have an electronic copy that I

1 can kind of . . .

2 MR. COLEMAN: I've got it right here.

3 So first I'm going to mark this exhibit.

4 38, are we?

5 MS. SPENCER: 9.

6 MR. COLEMAN: 39. I'm sorry. I only

7 have three of these.

8 MS. SPENCER: I'll share with the

9 witness. We can make a copy after the fact.

10 MR. BECKWORTH: I'll give you my copy.

11 MS. SPENCER: Thank you, Brad.

12 (Portenoy Exhibit 39 was marked
13 for identification.)

14 BY MR. COLEMAN:

15 Q. So this is a letter to you from Craig
16 Landau, M.D., who is the chief medical officer at
17 Purdue; is that correct?

18 A. Yes.

19 Q. And the letter is dated May 12, 2009 --

20 A. Yes.

21 Q. -- is that correct?

22 A. Yes.

23 Q. And it says, "As a specialty pharmaceutical
24 company focused primarily on the development of new
25 therapies for managing pain, Purdue is constantly

1 evaluating new product opportunities. To supplement
2 our significant internal expertise in evaluating such
3 opportunities, we are forming a multidisciplinary
4 external advisory board. As a recognized expert in
5 your discipline, we would be pleased to have you as
6 a member of that board."

7 Did I read that correctly?

8 A. Yes.

9 Q. I'm going to direct your attention to your
10 declaration, paragraph 30 on page 19 and little (i).
11 And it says, "On December 16, 2009, I entered into a
12 master health care professional consulting [sic]
13 services agreement with Purdue, running through
14 December 31, 2011."

15 And I'm skipping down. "I believe based
16 on the date of this agreement, this concerned the
17 launch of Purdue's Butrans product. I was
18 compensated a total of \$40,000 plus expenses for my
19 work on this project."

20 Is that correct?

21 A. Yes.

22 Q. So does this letter represent the retention
23 that ultimately went to the December 6 agreement?

24 A. Yes, I believe it does.

25 Q. So I have that agreement. I'm not going to

1 mark it unless you want to see it, need it to
2 refresh your recollection. But this -- so that's
3 the retention that you're talking about here?

4 A. When you -- just define the word "retention"
5 for me. What do you mean?

6 Q. Entered into -- well, you're right.
7 I shouldn't use that word. That is the consulting
8 services agreement that you're talking about here?

9 A. Yes, it was --

10 Q. It's linked to --

11 A. Yes.

12 Q. -- this offer from Craig Landau in the
13 March 12 letter?

14 A. Yes.

15 Q. Can you tell us what an advisory board is,
16 or your understanding of an advisory board in a
17 pharmaceutical company.

18 A. So my understanding is that a pharmaceutical
19 company will impanel a group of experts. Sometimes
20 it's for a single meeting to discuss a specific
21 issue. It could be, for example, to discuss the
22 development of a research protocol. Or it could be
23 to discuss the unmet need for pain management in a
24 specific population.

25 Sometimes an advisory group will be

1 brought together for a series of meetings to provide
2 advice to the drug company about their product
3 pipeline, what drugs they're working on
4 preclinically to determine which ones should go into
5 clinical trials. So they're seeking -- the drug
6 company executives are seeking the advice of experts
7 that are not employed by the drug company.

8 And so they -- each of these panels will
9 have different types of people. I would usually
10 participate sort of representing expertise in
11 clinical pain management and also expertise in
12 clinical trials development.

13 So I did advisory boards for the design
14 of research protocols and I did advisory boards to
15 talk about the role of new products, for example, in
16 pain medicine.

17 Q. Right. So here you believe that this had
18 to do with a Purdue product, Butrans; is that
19 correct?

20 A. Among other things.

21 Q. Right. So -- and can you describe what
22 Butrans was.

23 A. Butrans is a --

24 Q. Is. Is.

25 A. Is, yes. Is a patch that contains the

1 opioid called buprenorphine. And it's a transdermal
2 patch that can provide analgesia for many days.

3 Q. So on the advisory panel, I assume as a
4 pain specialist, they would say, Here's a product
5 that we've either developed or are thinking of
6 developing; would this be something that you would
7 consider using in your practice?

8 A. Sometimes that question would arise. But
9 typically the people on the advisory board wouldn't
10 be representative of people in general practice.
11 They would be representatives of the academic
12 community.

13 Q. Right.

14 A. So they'd want to know about -- more about
15 the status of the pain research that was being done.
16 They'd like us -- like, for example, would want to
17 analyze whether or not there are patients who have
18 chronic pain, who are frail. And an opioid might be
19 considered, but the dosing -- the available tablets
20 of the different drugs in the marketplace wouldn't
21 make it possible to treat those patients safely.

22 So it's typically not -- honestly, when
23 I did these advisory boards, they didn't -- weren't
24 asking me about my practice. They would be asking
25 me about areas of my expertise that might relate to

1 the science, might relate to my clinical trials
2 knowledge, that sort of thing.

3 Q. Right. So Butrans is -- it still is on the
4 market -- a transdermal patch; is that what you said?

5 A. Yes.

6 Q. And I believe the dosing is once a week?

7 A. Yes.

8 Q. So the idea was if Purdue could put out a
9 patch that you could use once a week rather than
10 taking medication every day, that that would be
11 advantageous to certain patient populations in terms
12 of compliance, consistency, other issues like that?

13 A. That's correct. And also buprenorphine was
14 not a drug that was being used for chronic pain, and
15 it has a unique pharmacology. So the discussion
16 about the Butrans patch was whether or not that
17 pharmacology might prove to be of specific benefit
18 in some populations.

19 Q. Right. Doctor, you're aware that Butrans
20 was never really a commercial success?

21 A. I didn't know that.

22 Q. Well, I'll represent that to you. But
23 there was significant -- you know, there was
24 marketing activity on Butrans. So would you agree
25 that merely marketing an opioid product isn't going

1 to make it a commercial success?

2 A. I think I don't know enough about the
3 phrase "merely marketing." I would imagine that
4 marketing can take all different kinds of forms and
5 have all different sorts of resources behind it.
6 So I wouldn't be able to comment on whether or not
7 "merely marketing" is enough.

8 Q. Fair enough. I'll try to ask a more
9 specific question. If you have a medication that
10 does not fit a patient population's need, do all the
11 drug representatives in the world change that fact?

12 A. So if you're asking me, can products come
13 on the market and not do well because they don't
14 meet an existing clinical need? And the answer to
15 that question, I believe, is yes.

16 You can have a product fail because it
17 doesn't -- it doesn't pose any advantage over other
18 products or its price is too high relative to
19 existing products that do just as well. Or what the
20 company thought was an advantage, like a new
21 delivery system, was not viewed as advantageous by
22 the doctors. So a company -- a product can fail if
23 there's no clinical perceived need.

24 Q. So a sales representative could have some
25 influence on whether a product gets the attention,

1 but you can't turn a product that doesn't have the
2 characteristics that the patient population and the
3 medical community is looking for into a successful
4 launch or a successful drug; is that a fair
5 statement?

6 MS. SPENCER: You can answer to the
7 extent you -- I'll object, but you can answer to the
8 extent you know.

9 THE WITNESS: Yeah. I think the
10 statement is a little too broad --

11 BY MR. COLEMAN:

12 Q. Okay.

13 A. -- and there are too many variables in that
14 equation that I can't comment on. But to reiterate
15 what I said, can a product come on the market and
16 then fail despite the intent of the manufacturer for
17 the product to do well, and the answer is obviously
18 yes. And presumably that occurs because the
19 perceived clinical need doesn't materialize.

20 MR. COLEMAN: Okay. I have a few quick
21 cleanup questions. I'm just going to quickly check
22 my time to make sure . . .

23 THE VIDEO OPERATOR: Seven hours,
24 11 minutes.

25 MR. COLEMAN: Okay. I'm going to do

1 five minutes and pass.

2 MR. BECKWORTH: Okay.

3 BY MR. COLEMAN:

4 Q. On the -- let's stay on the declaration.

5 On paragraph 46, the very last line, the paragraph
6 starts with "I have long believed that direct-to-
7 consumer advertising in the opioid context is a
8 terrible idea."

9 We went through this paragraph earlier
10 in the day, and I'm not going to revisit it. I did
11 want to clarify one comment. Now, first, direct-to-
12 consumer advertising we were talking about is ads on
13 TV, ads in Women's Wear Daily, ads in a magazine
14 that you would pick up at the dentist's office.

15 Is that your understanding as well?

16 A. Yes.

17 Q. Okay. So the last sentence says, "I first
18 saw a full-page color advertisement for OxyContin in
19 a general medical journal."

20 There seems to be a disconnect between
21 that statement and the beginning of the paragraph,
22 so -- I understand that the full-page color ad could
23 be in a general medical journal but I don't think
24 you were meaning to suggest it was a direct to
25 consumer?

1 MR. BECKWORTH: Objection.

2 THE WITNESS: No. I take the point --
3 no. These are two different types of advertising.
4 The first part of the paragraph is speaking to
5 direct-to-consumer like a television ad, and the
6 second part of the paragraph is talking about
7 advertising in a medical journal that would be read
8 by physicians.

9 MS. SPENCER: One clarification. The
10 sentence right before the one that you read reads,
11 "This concern about advertising also extends to
12 primary care physicians themselves."

13 THE WITNESS: That's the transition.

14 MR. COLEMAN: Okay. That didn't jump
15 out. That's why I clarified it.

16 THE WITNESS: Okay.

17 BY MR. COLEMAN:

18 Q. Going to a document that was designated as
19 Exhibit 22. I'll give you a chance to get it and
20 reacquaint yourselves with it.

21 MS. SPENCER: This needs to be in your
22 pile because it's the official one.

23 THE WITNESS: Yes.

24 MS. SPENCER: 22?

25 MR. COLEMAN: 22, yes.

1 THE WITNESS: Yes.

2 BY MR. COLEMAN:

3 Q. Do you see down at the bottom -- whoops,
4 I'm ambushing you. I'm sorry.

5 A. That's all right.

6 Q. Do you see down at the bottom it says page --
7 their page 10, and the next one says page 11?

8 A. Yes.

9 Q. So does that suggest that this is from a
10 larger document?

11 A. Yes.

12 Q. Were you shown the larger document at any
13 time?

14 A. No.

15 Q. Are you familiar with the larger document?

16 A. No.

17 Q. So you were asked to comment on the calls
18 on M.D.s and the resulting prescriptions based on
19 those calls; is that correct?

20 A. Yes.

21 Q. But you don't know what type of M.D.s these
22 are; is that correct?

23 A. That's correct.

24 Q. From this? Would it be safe to assume that
25 there are more calls to doctors who are pain

1 specialists or practice in that area --

2 MR. BECKWORTH: Objection. Sorry.

3 BY MR. COLEMAN:

4 Q. -- or there's certainly nothing in this
5 document to suggest that is not the case?

6 A. That's correct.

7 Q. And if that were the case, you would expect
8 to see more prescriptions from that population;
9 would you agree with that?

10 A. I would agree with that.

11 Q. So a quick question about Document 25.

12 A. Um-hum.

13 Q. So you were shown this document earlier in
14 the day, correct?

15 A. Yes.

16 Q. You had never seen this document before,
17 as I recall?

18 A. Right.

19 Q. And you were shown one paragraph. If it
20 wasn't on the last page, it was pretty much at the
21 end. I believe it was on page 25. But that's the
22 paragraph you were shown and asked to read; is that
23 correct?

24 A. Yes.

25 Q. Or thereabouts?

1 A. Yes.

2 Q. You were not shown on page 9 Purdue's --
3 and, again, this document is "Corporate Reputation
4 and Visibility Strategic Plan."

5 You were not shown extensive information
6 about creating a patient -- I'm on page 9.

7 A. Yes.

8 Q. -- a patient access platform? I'm going to
9 not read that because of the time constraints. Or
10 the anti-diversion/abuse message platform. And that
11 goes on for two pages.

12 Do you see that?

13 A. Yes.

14 Q. So that was not part of what you discussed
15 earlier on in the day?

16 A. That's true.

17 MR. COLEMAN: Dr. Portenoy, I have one
18 last exhibit that I will mark.

19 MS. SPENCER: We're up to 40.

20 (Portenoy Exhibit 40 was marked
21 for identification.)

22 MR. COLEMAN: Let me know when you've
23 had a chance to . . .

24 MS. SPENCER: Just one moment.

25 THE WITNESS: Okay.

1 MS. SPENCER: Hold on. I'm not ready.
2 I'm sorry. I take responsibility, but I need to
3 read this.

4 Go ahead. Thank you, sorry.

5 BY MR. COLEMAN:

6 Q. So this is an email exchange, correct?

7 A. Yes.

8 Q. It's an email exchange between you and
9 several members of -- several employees of Purdue;
10 is that correct?

11 A. Yes.

12 Q. And if you read backwards with it, the
13 first email on the string is from May 10, 2013;
14 is that correct?

15 A. Yes.

16 Q. And it says, "Dear Pam, I hope all is well.
17 I have a quick question. I and many others are
18 named in a suit to which the company is a party.
19 You may know about it. My hospital's attorneys
20 wanted me to find out whether there had been
21 discussions or plans to provide defense or
22 indemnification to the outside academic physicians
23 (like me). Are you able to tell me who I could
24 email or could call to find out about this? Thanks
25 very much. Russ."

1 Did I read that correctly?

2 A. Yes.

3 Q. Did you make this request to any other
4 pharmaceutical company --

5 A. No.

6 Q. -- that you worked for?

7 So you just -- at the hospital's
8 suggestion, you asked Purdue to indemnify and defray
9 attorney expenses at least for the lawsuits that you
10 are now being named in?

11 A. No --

12 MS. SPENCER: Objection. That is a
13 mischaracterization of this email. I'll let him
14 answer, but . . .

15 BY MR. COLEMAN:

16 Q. Okay. Go ahead.

17 A. This lawsuit has nothing to do with the
18 current litigation. This lawsuit is from some years
19 ago and involved a gentleman, I believe in the State
20 of South Carolina, who developed the disease of
21 addiction and engaged in some criminal activity and
22 ended up in prison and chose to sue Purdue and a
23 number of physicians for creating an environment
24 that caused him to become addicted. And it has
25 nothing at all to do with the current opioid

1 litigation.

2 I went to my hospital attorney -- I was
3 a full-time employee of Beth Israel, and I went to
4 the hospital attorney and asked whether or not I
5 could get some help from the hospital attorney in
6 dealing with this suit.

7 And the hospital attorney said no, that
8 it wouldn't be appropriate, but asked me to find out
9 whether or not Purdue would have some involvement in
10 helping the physicians, the individual physicians
11 who were named defendants on that suit.

12 As you see, Purdue declined to do that.
13 And I and the other physicians hired counsel in
14 South Carolina to put in a motion to have the case
15 dismissed, and it was dismissed.

16 Q. So did there come a time when you were sued
17 in what you are terming this litigation, this series
18 of litigations?

19 MS. SPENCER: If that's the question,
20 did there come a time when you were sued in this
21 series of litigations?

22 MR. COLEMAN: Yes.

23 MS. SPENCER: You can answer that
24 question. I'm going to caution, you know, that if
25 you're treading close to privilege areas, I'm going

1 to object.

2 MR. COLEMAN: No. All I'm going to do
3 is --

4 BY MR. COLEMAN:

5 Q. Go ahead.

6 A. Yeah.

7 Q. That was a "yes," correct?

8 A. Yes.

9 Q. And did you seek indemnification from
10 Purdue in that instance?

11 A. No.

12 Q. You never sought indemnification from
13 Purdue for the current litigations?

14 A. No.

15 Q. Did you seek indemnification from any of
16 the defendants?

17 A. No.

18 MR. COLEMAN: Okay. No more questions.
19 Thank you so much.

20 MS. SPENCER: Just so we have a sense,
21 where are we on time?

22 THE VIDEO OPERATOR: Seven hours,
23 22 minutes.

24 MS. SPENCER: Do you think you'll be
25 there or close?

1 MR. ERCOLE: I may go over a little bit.

2 MS. SPENCER: I'm just asking for a
3 ballpark, there or close?

4 MR. ERCOLE: I will do my best to do
5 that and then we can have a discussion if things are
6 going longer, but yes, that's my intent.

7 MR. BECKWORTH: Just so you know, I
8 finished two minutes short.

9 MR. ERCOLE: I appreciate that.

10 MR. BECKWORTH: See what you got.

11 EXAMINATION

12 BY MR. ERCOLE:

13 Q. Good evening, Dr. Portenoy. I'm going to
14 do my best not to show you any additional exhibits
15 because I know you've seen a lot of exhibits today.

16 Would you agree that --

17 MS. SPENCER: Can I just -- for the
18 record, if you could identify yourself for the
19 witness and who you represent.

20 MR. ERCOLE: Sure.

21 BY MR. ERCOLE:

22 Q. My name is Brian Ercole, and I represent
23 several of the manufacturers in this particular
24 litigation, and we'll get into who some of those
25 are.

1 Would you agree that opioid
2 manufacturers are not all the same?

3 A. I'm going to ask you to clarify when you
4 say "not all the same." In what context?

5 Q. Sure. There are different manufacturers of
6 opioids, correct?

7 A. Correct.

8 Q. And those companies manufacture different
9 opioid medicines, correct?

10 A. Yes.

11 Q. And those companies sell different opioid
12 medicines, correct?

13 A. Yes.

14 Q. And some of those medicines may be generic
15 opioids; is that fair?

16 A. Yes.

17 Q. And some of those medicines may be brand
18 medications; is that fair?

19 A. Yes.

20 Q. And is it also fair to say that different
21 opioid companies engage in different types of
22 marketing?

23 A. I don't -- I can't answer specifically, but
24 I think that that's a fair statement.

25 Q. Sure. And is it fair to say that different

1 opioid manufacturers may say different things about
2 their medicines?

3 A. That's a fair statement too.

4 Q. And is it fair to say that with respect to
5 opioid medicines, that they differ?

6 A. Yes.

7 Q. Some are long-acting opioids?

8 A. Yes.

9 Q. Some are short-acting opioids?

10 A. Yes.

11 Q. And there are other differences as well,
12 correct?

13 A. Yes.

14 Q. Different delivery systems, for instance?

15 A. That's right.

16 Q. Dr. Portenoy, have you ever heard of Watson
17 Laboratories, Inc.?

18 A. Yes.

19 Q. And have you heard about Watson
20 Laboratories, Inc. in connection with this case?

21 A. I --

22 MS. SPENCER: When you say "this case,"
23 you mean the State of Oklahoma versus these
24 companies involved here today, or do you mean --

25 MR. ERCOLE: I mean -- Sorry. I didn't

1 mean to cut you off.

2 MS. SPENCER: -- the more general opioid
3 litigation that is pending, you know, here and
4 elsewhere?

5 MR. ERCOLE: Sure.

6 BY MR. ERCOLE:

7 Q. I mean this particular case, the State of
8 Oklahoma versus the pharmaceutical manufacturers,
9 the reason why you're here today.

10 A. Yeah. I'm not aware that I heard about
11 Watson Laboratories in this context.

12 Q. Do you recall any communications that
13 you've had with Watson Laboratories, Inc.?

14 A. I don't.

15 Q. Are you aware of any marketing that Watson
16 Laboratories, Inc. has done?

17 A. I'm not.

18 Q. Are you aware of any funding that Watson
19 Laboratories, Inc. has given to you or any of your
20 employers?

21 A. Not that I recall.

22 Q. Dr. Portenoy -- and just to clarify, going
23 forward, when I refer to "this case," I'm referring
24 to the State of Oklahoma case --

25 MS. SPENCER: Thank you.

1 BY MR. ERCOLE:

2 Q. -- and if you do have a question or you're
3 not understanding what I'm saying, please just raise
4 that issue --

5 A. Sure.

6 Q. -- and I'll clarify for you.

7 A. Thank you.

8 Q. Dr. Portenoy, are you familiar with the
9 entity Actavis LLC?

10 A. Not specifically.

11 Q. Are you aware of any communications that
12 you've ever had with Actavis LLC?

13 A. I'm not.

14 Q. Are you aware of any marketing ever done by
15 Actavis LLC?

16 A. Not that I'm aware of.

17 Q. Are you aware of any funding Actavis LLC
18 has ever given to you or any of your employers?

19 A. Not that I recall.

20 Q. Dr. Portenoy, are you familiar with the
21 entity Actavis Pharma, Inc.?

22 A. Not that I recall, no.

23 Q. Are you aware of -- Strike that.

24 Have you had any communications with
25 Actavis Pharma, Inc.?

1 A. No.

2 Q. Are you aware of any marketing of any
3 products that Actavis Pharma, Inc. has done?

4 A. Not that I'm aware of.

5 Q. Are you aware of any funding that Actavis
6 Pharma, Inc. has given to you or any of your
7 employers?

8 A. No.

9 Q. Are you aware of any of the products that
10 Actavis Pharma, Inc. manufactures?

11 A. I'm not. But I have to say that, as you
12 know, in the pharmaceutical industry, names change
13 and companies are acquired by other companies. And
14 it's possible that I've lost track of what products
15 have been sold to other companies.

16 So I don't have a recollection about
17 Actavis. But if I found out, for example, that they
18 were a manufacturer of one of the drugs involved in
19 the litigation, it wouldn't surprise me. It means
20 that they just acquired that product and I wasn't
21 aware of it.

22 Q. Sir, sitting here today, you're not aware
23 of any products that Actavis Pharma, Inc.
24 manufactures, correct?

25 A. I am not aware, no.

1 Q. And you're not aware of any products that
2 Actavis Pharma, Inc. has manufactured in the past --

3 A. No.

4 Q. -- correct?

5 A. That's correct.

6 Q. Would the same apply to Actavis LLC?

7 A. Yes.

8 Q. Would the same apply to Watson

9 Laboratories?

10 A. Yes.

11 Q. Dr. Portenoy, if you can pull up your
12 declaration. I think it's Exhibit 2.

13 A. I have it, yes.

14 Q. Great. You agree, I think you testified
15 before, that this case is a very serious case,
16 correct?

17 A. Yes.

18 Q. And is it fair to say that the assertions
19 made in your declaration are serious too, correct?

20 A. I think that's true.

21 Q. Sure. If you turn to paragraph 30 of your
22 declaration --

23 A. Um-hum.

24 MS. SPENCER: Page 19.

25

1 BY MR. ERCOLE:

2 Q. Yes. Take your time to get there.

3 A. Um-hum.

4 Q. The State asked you some questions earlier
5 about paragraph 30. Do you recall that?

6 A. Yes.

7 Q. And by "the State" -- and I mean --

8 MS. SPENCER: We know.

9 BY MR. ERCOLE:

10 Q. -- Mr. Beckworth, who's representing the
11 State here.

12 A. Yes.

13 Q. And Mr. Beckworth walked you through some
14 of the examples from (a) to (p) in that declaration,
15 correct?

16 A. Yes.

17 Q. So if you can turn to paragraph 30(c),
18 do you see that?

19 A. Yes.

20 Q. And it refers to, in paragraph 30(c),
21 a seminar titled "Breakthrough pain curriculum
22 development workshop"?

23 A. Yes.

24 Q. And in there, it says, "I believe this was
25 financed ultimately by Cephalon, Inc. related to its

1 drug Fentora"; do you see that?

2 A. Yes.

3 Q. Are you aware of anything false or
4 misleading in that seminar, "Breakthrough pain
5 curriculum development workshop"?

6 A. I don't have a specific recollection of
7 that workshop. As a general rule, I would say no,
8 there was nothing false or misleading in workshops
9 like that.

10 Q. And why would you say that as a general
11 rule?

12 A. I participated in a number of educational
13 programs devoted to breakthrough pain. Breakthrough
14 pain was a specific interest of mine. I developed
15 the first measurement tool for that type of pain and
16 was involved in designing the research protocols
17 that demonstrated how the short-acting drugs work
18 for breakthrough pain. So it was a specific area of
19 interest.

20 So I participated in a number of those
21 kinds of programs. And all the programs that I
22 participated in were CME programs that -- for which
23 I created my own messages, used my own slides.
24 There was never any effort on the part of a funding
25 company, the sponsor, to change my messages or ask

1 me to use specific slides.

2 Q. And paragraph 30(c) indicates that you were
3 compensated \$3,000 by Advanced Strategies in
4 Medicine.

5 Do you see that?

6 A. Yes.

7 Q. Was there anything wrong with being
8 compensated for putting together a seminar that was
9 neither false nor misleading?

10 A. No, I don't think so.

11 Q. If you turn to paragraph 30(e) -- Strike
12 that. The next sort of bullet down, paragraph 30(d),
13 do you see that?

14 A. Yes.

15 Q. It says, "On May 15, 2007, I worked on an
16 advisory board for Cephalon, Inc. concerning the
17 drug Fentora, for which I was compensated \$3,500"?

18 A. Yes.

19 Q. Did I read that correctly?

20 A. Yes.

21 Q. And are you aware of anything false or
22 misleading that was discussed at that advisory board
23 meeting on May 15, 2007?

24 A. I'm not aware of anything.

25 Q. Was there anything inappropriate about

1 being compensated for your work in connection with
2 that advisory board meeting?

3 A. No.

4 Q. And is it fair to say that that advisory
5 board meeting was an internal meeting at Cephalon?
6 Strike that. That's a bad --

7 MS. SPENCER: I was going to say, he can
8 answer if he recalls.

9 MR. ERCOLE: Fair enough.

10 BY MR. ERCOLE:

11 Q. In connection with that advisory board
12 meeting, was there any marketing done external in
13 connection with that?

14 MS. SPENCER: Objection.

15 You can answer if you recall.

16 THE WITNESS: Yeah. I don't recall this
17 specific meeting in 2007. So I really can't answer
18 that.

19 BY MR. ERCOLE:

20 Q. As a general matter, did advisory boards
21 engage in marketing?

22 A. No. As a general matter, the advisory
23 boards did not discuss marketing.

24 Q. And sitting here today, with respect to the
25 May 15, 2007 advisory board meeting for Cephalon,

1 you're not aware of any marketing that was done in
2 connection with that particular meeting?

3 A. I'm not aware of any, no.

4 Q. And you're not aware of anything false or
5 misleading said during that meeting, correct?

6 A. That's correct.

7 Q. Paragraph -- turn to the next paragraph,
8 paragraph 30(e). It says, "On November 6, 2007,
9 I presented a continuing medical education program,
10 'Meet the patients: Individualizing therapy for
11 persistent and breakthrough pain.'" "

12 Do you see that?

13 A. Yes.

14 Q. Are you aware of anything false or
15 misleading -- Strike that.

16 In connection with that CME program, did
17 you independently develop the content of that
18 program?

19 A. I don't remember the specific program, but
20 I'll answer yes to that because I developed the
21 content for all of the educational programs that I
22 did.

23 Q. And with respect to any CME programs you
24 did for -- Strike that.

25 With respect to any CME programs that

1 were sponsored by Cephalon, is it fair to say that
2 Cephalon never controlled the content of those
3 programs?

4 A. That I was involved with?

5 Q. Yes.

6 A. Yes, it's fair to say that.

7 Q. And to the best of your recollection, the
8 November 6, 2007 CME program was no exception?

9 A. That's -- To the best of my recollection,
10 that's true.

11 Q. And it indicates in that paragraph that you
12 were compensated \$2,000 by Advanced Strategies in
13 Medicine; do you see that?

14 A. Yes.

15 Q. Anything improper about you being
16 compensated for your work in creating that CME?

17 A. I don't think so, no.

18 Q. If you go down to paragraph 30(j) --

19 A. Yes.

20 Q. -- it says, "On April 1, 2009, I
21 participated in a Fentora medical scientific
22 advisory board meeting"?

23 A. Yes.

24 Q. Do you see that?

25 A. Yes.

1 Q. And is the medical scientific advisory
2 board meeting referenced there the same type of
3 advisory board meeting that you've talked about
4 already?

5 A. I don't remember this specific meeting.
6 I remember, for example, participating in a meeting
7 in which we designed a new research protocol for
8 studying Fentora in -- as a repeated dose
9 administration.

10 So the answer is, it could have been on
11 a research protocol, or it could have been of the
12 type I mentioned before where we were talking about
13 the role of treating breakthrough pain as part of
14 pain medicine.

15 Q. Anything inappropriate that you recall
16 taking place on April 1, 2009?

17 A. No, not that I recall.

18 Q. Anything inappropriate or wrong from your
19 perspective in connection with participating in an
20 advisory board meeting for Fentora?

21 A. No.

22 Q. If you turn to paragraph 30(m), it says,
23 "In May 2010, I moderated an online program called
24 'Medico-legal issues, clinical guidelines and opioid
25 dose conversions.'"

1 Do you see that?

2 A. Yes.

3 Q. And that was for the website
4 emergingsolutionsinpain.com?

5 A. Yes.

6 Q. Do you recall anything false or misleading
7 that you did in connection with that online program?

8 A. No.

9 Q. Do you recall anything false or misleading
10 with respect to that online program?

11 A. No.

12 Q. Would you have independently created the
13 content of that program?

14 A. Yes.

15 Q. Cephalon would not have controlled the
16 content of that program, correct?

17 A. Let me just clarify what I just said.

18 Q. Sure.

19 A. I would have either -- for a program of
20 this type -- I don't have a specific recollection of
21 this program, but for a program of this type, I
22 would either have created the programming or a
23 medical education company would have drafted the
24 programming, and then I would have edited it so that
25 it was appropriate.

1 Q. And is it fair to say that the content of
2 that program was independently created by others
3 than Cephalon?

4 A. Yes.

5 Q. And anything in your mind that was somehow
6 inappropriate about receiving \$2,000 in connection
7 with that program?

8 A. No.

9 Q. And is it fair to say that that \$2,000 that
10 you received never influenced the content of that
11 program?

12 A. Yes. That's true.

13 Q. And is it fair to say that with respect to
14 all of the different -- the different programs and
15 advisory board meetings we just discussed, that any
16 payment you received in connection with those never
17 influenced your views?

18 A. That's true.

19 Q. And never influenced the content of those
20 programs?

21 A. That's true.

22 Q. And would the same -- if you take a look at
23 paragraph 30(p), it says, "On February 11, 2011,
24 I entered into an advisory board agreement with
25 Cephalon, Inc."?

1 A. Yes.

2 Q. Do you recall anything false or misleading
3 discussed? Strike that.

4 Do you know whether or not you actually
5 engaged in any type of advisory board discussions
6 after entering into that agreement in February 11?

7 A. I don't recall, no.

8 Q. And you don't recall any false or
9 misleading discussions taking place at any advisory
10 board meeting that you've ever had with Cephalon;
11 is that fair to say?

12 A. That's fair to say, yes.

13 Q. So with respect to the examples we just
14 discussed, there's no mention of Teva
15 Pharmaceuticals USA; is that correct?

16 A. Yes.

17 Q. And will you agree that for purposes of
18 moving this forward when I refer to -- I'm going
19 to use "Teva USA" as a shorthand for "Teva
20 Pharmaceuticals USA"? Is that fair? Can we get on
21 the same page there?

22 A. That would be fine.

23 Q. Do you recall any communications that
24 you've had with Teva USA?

25 A. No.

1 Q. Are you aware of any marketing that Teva
2 USA has done?

3 A. No, I'm not.

4 Q. Are you aware of anything false or
5 misleading that Teva USA has said about any of its
6 products?

7 A. No.

8 Q. Can we turn to paragraph 32 of your
9 declaration, sir. Do you see that?

10 A. Yes.

11 Q. And if you turn -- it starts on page 21 and
12 goes to page 22.

13 A. Yes.

14 Q. And it says in here, "A responsible
15 company" -- Do you see the sentence that starts,
16 "A responsible company should disclose relevant
17 risks when communicating with the public"?

18 MS. SPENCER: It's on the next page.

19 BY MR. ERCOLE:

20 Q. Sorry, it goes to paragraph --

21 A. Yes.

22 MS. SPENCER: I'm just facilitating.

23 MR. ERCOLE: Thank you.

24 THE WITNESS: Yes.

25

1 BY MR. ERCOLE:

2 Q. Are you aware of Cephalon not disclosing
3 any relevant risks when communicating with the
4 public of its medicine?

5 A. I'm not aware of communications to the
6 public from Cephalon.

7 Q. And it goes on to say, "the risks
8 associated with opioid abuse and addiction were
9 known at that time."

10 Do you see that?

11 A. Yes.

12 Q. That would have been in 2004?

13 A. Yes.

14 Q. So in 2004, in your declaration, you're
15 confirming that the risks associated with opioid
16 abuse and addiction were known, correct?

17 A. Correct.

18 Q. And they would have been known within the
19 medical community, correct?

20 A. Yes.

21 Q. If you turn to paragraph 34 of your
22 declaration, I believe it's page 23.

23 A. Yes.

24 Q. It says, "I believe that, over the years,
25 some defendant drug companies have used my work to

1 promote opioids by referencing the positive
2 statements that I made repeatedly without providing
3 the background, analysis of the literature, and
4 cautions that accompanied these positive statements."

5 Do you see that?

6 A. Yes.

7 Q. Are you aware of any instances where
8 Cephalon did that?

9 MS. SPENCER: All you can answer is what
10 you know.

11 THE WITNESS: Yes. So I'm not aware of
12 an example where Cephalon has done that, no.

13 BY MR. ERCOLE:

14 Q. And you're not aware of an example of Teva
15 USA doing that?

16 A. No.

17 Q. If you turn to paragraph 35 of your
18 declaration. Do you see that, sir?

19 A. Yes.

20 Q. And I think it may be the fourth sentence
21 down. It says, "Although I personally was never
22 influenced to say things I did not believe," do you
23 see that?

24 A. Yes.

25 Q. What did you mean by that?

1 A. Essentially what we were saying before.
2 That in the funding that I received for educational
3 programs or in the funding that I received for
4 research projects, I personally was never asked to
5 craft a specific message or not -- not convey a
6 message that I originally put into some educational
7 materials or to do a specific kind of research or
8 change my research methodology. I haven't
9 personally experienced that.

10 Q. And if you keep going where there's a
11 reference to "they used the positive statements that
12 I made about opioids to portray opioid treatment as
13 safe and effective without the accompanying
14 discussion of risk that I included in the papers,
15 chapters, and lectures I produced beginning in the
16 1980s."

17 Do you see that?

18 A. Yes.

19 Q. Are you aware of any instance where
20 Cephalon did that with respect to opioids?

21 A. Yeah. I don't have any specific
22 recollection of that -- of those materials from
23 Cephalon.

24 Q. About Teva USA?

25 A. No.

1 Q. If you turn to paragraph 36.

2 A. Yes.

3 Q. It says -- last sentence there --

4 "I believe that the drug companies created material
5 that narrowly focused on the potential for safe and
6 effective treatment of chronic noncancer pain, some
7 of which was attributed to my work, but failed to
8 include an adequate and balanced discussion of the
9 limitations in the relevant science and the risks as
10 they were then known."

11 Do you see that?

12 A. Yes.

13 Q. Any instances where Cephalon did that?

14 MR. BECKWORTH: Objection.

15 MS. SPENCER: You can answer to the
16 extent that you know.

17 MR. BECKWORTH: Yeah. That's my
18 objection. Are you asking him if he remembers or if
19 there are, in fact, any?

20 MR. ERCOLE: Well, I appreciate the
21 objection. So I'll let the question stand.

22 BY MR. ERCOLE:

23 Q. And you can answer the question if --

24 A. Yeah. I don't recall any.

25 Q. So sitting here, you don't recall any

1 instances where that happened with respect to
2 Cephalon?

3 A. That's correct.

4 Q. Would the same hold true with respect to
5 Teva USA?

6 A. Yes.

7 MR. BECKWORTH: Same objection.

8 BY MR. ERCOLE:

9 Q. If you turn to paragraph 38, do you see
10 that?

11 A. Yes.

12 Q. It's a reference to the American Pain
13 Foundation?

14 A. Yes.

15 Q. And was the American Pain Foundation formed
16 to help patients -- Strike that.

17 Was the American Pain Foundation formed
18 to help patients?

19 A. Patients, families, and the lay public.

20 Q. Do you think it did?

21 A. Yes.

22 Q. And how do you think it did?

23 A. It did a variety of programs that
24 accomplished a lot of good. For example, it had a
25 hotline that patients in distress or family members

1 would call. And the hotline received thousands of
2 calls from distressed patients asking for
3 information. It created educational materials at a
4 patient reading level that it distributed about pain
5 management. Those kind of materials weren't
6 available anywhere else.

7 Q. And if you go down -- And the American Pain
8 Foundation is no longer in existence today, correct?

9 A. That's correct.

10 Q. If you go down to the sentence that begins,
11 "Although management and board members were never
12 induced to create specific messages or change a
13 message that was proposed as part of any project,"
14 do you see that?

15 A. Yes.

16 Q. What do you mean by that, sir?

17 A. I'm not aware of any time that a project
18 that was funded by a pharmaceutical company as part
19 of a grant request was needed to be changed, needed
20 to be modified because the drug company wasn't
21 comfortable with the project and requested specific
22 changes in the messages.

23 I think that all these grants were
24 considered to be unrestricted grants that would fund
25 the project that would be under the control of the

1 management of the APF.

2 Q. And would it be fair to say that to the
3 best of your knowledge, none of the pharmaceutical
4 companies that have been sued in this case
5 controlled the content of any product put out by the
6 American Pain Foundation?

7 A. To the best --

8 MR. BECKWORTH: Objection.

9 THE WITNESS: To the best of my
10 knowledge, that's true.

11 BY MR. ERCOLE:

12 Q. Would that hold true for the other third-
13 party societies that you were involved with?

14 A. Yes. To the best of my knowledge, that's
15 true.

16 Q. If you turn to paragraph 40 of your
17 declaration.

18 A. Yes.

19 Q. Do you see that? It says, "I understand
20 that pharmaceutical companies assisted in
21 publicizing these guidelines and relied on them in
22 marketing of publications."

23 Do you see that?

24 A. Yes.

25 Q. Are you aware of Cephalon ever doing that?

1 MR. BECKWORTH: Objection.

2 THE WITNESS: I don't have any --

3 MS. SPENCER: You can answer.

4 THE WITNESS: I don't have any specific
5 information about Cephalon.

6 BY MR. ERCOLE:

7 Q. Are you aware of Teva USA ever doing that?

8 MR. BECKWORTH: Same objection.

9 THE WITNESS: No.

10 BY MR. ERCOLE:

11 Q. And I assume certainly you were never aware
12 of Cephalon and Teva USA doing anything like that in
13 Oklahoma, correct?

14 MR. BECKWORTH: Objection.

15 THE WITNESS: Correct.

16 BY MR. ERCOLE:

17 Q. If you turn to paragraph 42 of your
18 declaration.

19 A. Yes.

20 Q. The first paragraph talks about opioid
21 therapy being an appropriate first-line therapy for
22 some types of -- for different types of pain; do you
23 see that?

24 A. Yes.

25 Q. And there's a reference there to, "Opioid

1 therapy is an appropriate first-line therapy
2 for . . . breakthrough pain in opioid-treated
3 patients with serious illness."

4 A. Yes.

5 Q. Do you see that?

6 A. Yes.

7 Q. And would that also apply in some instances
8 outside of the cancer context?

9 A. Let me just clarify the question. You're
10 asking whether patients who are appropriately
11 receiving chronic opioid therapy for noncancer pain
12 might also be appropriate for opioid treatment of
13 breakthrough pain?

14 Q. Yes, sir.

15 A. Yes, that's true.

16 Q. If you turn the page to paragraph 43.

17 A. Yes.

18 MS. SPENCER: It starts at the bottom of
19 that page, right, and then goes on?

20 MR. ERCOLE: Fair point.

21 BY MR. ERCOLE:

22 Q. It's paragraph 43 I'd like to direct your
23 attention to, but I'm going to refer to a statement
24 on the next page.

25 A. Okay.

1 Q. Do you see where it says -- and it's
2 probably the third sentence from the bottom -- it
3 says, "In retrospect, the inclusion of data from
4 studies (particularly the Porter and Jick letter)
5 that reflected clinical scenarios so removed from
6 the scenario of interest (long-term treatment of
7 chronic pain patients) should not have been used to
8 support the conclusion that opioid risk is very low."

9 Do you see that?

10 A. Yes.

11 Q. Are you aware of Cephalon ever using that
12 study to support the conclusion that opioid risk is
13 very low?

14 MR. BECKWORTH: Objection.

15 MS. SPENCER: You can answer.

16 BY MR. ERCOLE:

17 Q. You can answer.

18 A. I don't have any specific recollection or
19 awareness of that.

20 Q. How about Teva USA?

21 MR. BECKWORTH: Same objection.

22 THE WITNESS: No.

23 BY MR. ERCOLE:

24 Q. And certainly not in Oklahoma; is that fair?

25 MR. BECKWORTH: Same objection.

1 THE WITNESS: Yes, that's fair.

2 BY MR. ERCOLE:

3 Q. So if you turn to paragraph 45, the first
4 sentence says, "I believe that my work was, over a
5 period of years, used by drug companies to create
6 positive messaging about opioid therapy without a
7 concurrent disclosure and discussion of risks."

8 Do you see that?

9 A. Yes.

10 Q. Are you aware of Cephalon ever using your
11 work to create positive messaging about opioid
12 therapy without a concurrent disclosure and
13 discussion of risks?

14 A. I don't have a specific recollection of
15 Cephalon's marketing strategy that did that.

16 Q. How about Teva USA?

17 A. No.

18 Q. And this declaration, sir, is it fair to
19 say this is based upon your personal knowledge,
20 correct?

21 A. Yes.

22 Q. So when you were referring in paragraph 45
23 to drug companies, is it fair to say you weren't
24 referring to Cephalon?

25 MR. BECKWORTH: Objection.

1 THE WITNESS: You know, I think --
2 I think that the paragraph referred to -- the
3 paragraph referred to what happened in our society
4 as the opioids were being marketed. And I didn't --
5 I didn't specifically factor in which companies did
6 that.

7 It was sort of a general impression of
8 how the opioid manufacturers impacted -- potentially
9 impacted the way the drugs were used based on
10 marketing strategies that pushed positive messages
11 and didn't provide context or risks.

12 I don't have any recollection of
13 specific -- specific marketing strategies used by
14 Cephalon that would be an example of that.

15 BY MR. ERCOLE:

16 Q. And you agree that it's a pretty serious
17 assertion here, correct?

18 A. Yes.

19 Q. And this assertion is based upon your
20 personal knowledge, correct?

21 A. Yes.

22 Q. And sitting here today, you don't have any
23 personal knowledge of Cephalon ever engaging in that
24 type of conduct, correct?

25 MR. BECKWORTH: Objection. What he said

1 was he didn't recall, not that he has no personal
2 knowledge.

3 THE WITNESS: Right.

4 BY MR. ERCOLE:

5 Q. No. You can answer the question as I
6 phrased it.

7 A. I don't have any specific recollection of
8 that as I -- as I think back over the last 15 years.

9 Q. Do you have any personal knowledge?

10 A. That Cephalon --

11 MR. BECKWORTH: Objection.

12 THE WITNESS: That Cephalon engaged in
13 that kind of marketing?

14 BY MR. ERCOLE:

15 Q. Yes.

16 A. No. I can't say that I have any specific
17 knowledge of that.

18 Q. Do you have any specific knowledge of Teva
19 USA ever doing that?

20 A. No.

21 Q. And would that apply to all of the points
22 that we've been discussing in your declaration?

23 MS. SPENCER: I'm going to object to
24 that.

25 MR. ERCOLE: Fair enough.

1 MS. SPENCER: I mean, if you want to
2 say, Would that apply to all of the questions I've
3 previously asked specific to specific paragraphs
4 that I've identified, I'll let him answer that in
5 the interest of time.

6 MR. ERCOLE: Thank you. I didn't mean
7 to cut you off. I apologize.

8 BY MR. ERCOLE:

9 Q. So your counsel articulated a much better
10 and coherent question than I could.

11 A. Right.

12 Q. So let me ask what she asked, which is,
13 would the answer you just gave apply to all the
14 questions I previously asked specific to specific
15 paragraphs I've identified with respect to Cephalon?

16 MR. BECKWORTH: Objection.

17 MS. SPENCER: You can answer.

18 THE WITNESS: Yeah. Again, I'm trying
19 to be very precise, and I'm interpreting the
20 question as, do I have any specific recollection
21 today of witnessing marketing that included, for
22 example, positive messages without context and
23 without warnings from Cephalon. And I don't have
24 any specific recollection today as examples of that.

25

1 BY MR. ERCOLE:

2 Q. And is it fair to say, sitting here today,
3 you don't have any knowledge of that that you can
4 share with me today, correct?

5 MR. BECKWORTH: Objection.

6 BY MR. ERCOLE:

7 Q. You can answer the question.

8 A. Right. I don't have any knowledge --
9 I don't have any knowledge in the sense that I have
10 specific recollections of it.

11 Q. And that would apply to Teva USA too,
12 correct?

13 A. Yes.

14 Q. If you turn to paragraph 46 where you say,
15 "I have long believed" -- paragraph 46, is it fair
16 to say you describe -- you discuss direct-to-
17 consumer advertising?

18 A. Yes.

19 Q. Do you have any personal knowledge of
20 Cephalon engaging in direct-to-consumer advertising
21 with respect to opioids?

22 A. No.

23 Q. Do you have any personal knowledge of Teva
24 USA engaging in direct-to-consumer advertising with
25 respect to opioids?

1 A. So I should just make sure I understand the
2 question. I was told today earlier that there was
3 direct-to-consumer advertising. I was not aware of
4 it prior to being told, but I was told earlier
5 today. So that's the extent of my knowledge: what I
6 was told today.

7 Q. Who told you that there was direct-to-
8 consumer advertising today with respect to Teva USA?

9 A. Unless I'm misremembering, the --
10 Mr. Beckworth indicated that there was advertising
11 to older patients about the use of opioids to treat
12 pain.

13 Q. Would it surprise you to learn, sir, that
14 what Mr. Beckworth was referring to was not Teva USA?

15 A. Again, I just learned it for the first
16 time -- I heard it literally in this room earlier
17 today. So it wouldn't surprise me or not surprise
18 me. But that's the extent of what I know, is what I
19 heard today.

20 Q. And so if what you heard today actually
21 didn't involve Teva USA at all, would it be fair
22 then to say that you don't have any knowledge of any
23 direct-to-consumer advertising by Teva USA?

24 A. Yes, of course.

25 Q. And is it fair to say at least when you

1 authored this declaration, which was not -- you
2 didn't author this declaration today, did you?

3 A. No.

4 Q. Is it fair to say that when you authored
5 this declaration, you were not -- you had no
6 personal knowledge of any direct-to-consumer
7 advertising by Teva USA?

8 A. That's true.

9 Q. And certainly no direct-to-consumer
10 advertising by Teva USA in Oklahoma, correct?

11 A. Correct.

12 Q. Turn to paragraph 47.

13 A. Um-hum.

14 Q. It states, "I believe that drug companies
15 disseminated the results of positive clinical
16 studies of opioid drugs without providing important
17 information that would allow prescribers to
18 understand the extent to which a trial relates to
19 clinical practice."

20 Do you see that?

21 A. Yes.

22 Q. Do you have any personal knowledge of
23 Cephalon ever doing that?

24 A. I don't have any specific recollection of
25 Cephalon distributing publications of the randomized

1 clinical trials.

2 Q. Do you have any personal knowledge of Teva
3 USA ever doing something like that?

4 A. No.

5 Q. It goes on -- if you look down in this
6 paragraph, it says, "Drug companies often distribute
7 publications that describe explanatory trials, and I
8 believe that they do not create messaging at the
9 same time that helps physicians understand the
10 connection to practice."

11 Do you see that?

12 A. Yes.

13 Q. Any personal knowledge of Cephalon ever
14 doing that?

15 A. No, I don't have any specific recollection
16 of that.

17 Q. And any personal knowledge of Teva USA ever
18 doing that?

19 A. No.

20 Q. And I assume when you authored this
21 declaration, you didn't have any personal knowledge
22 of Cephalon or Teva USA doing that?

23 A. Correct.

24 Q. And would that answer apply to all of the
25 questions that I've asked so far: that when you

1 signed the declaration, you didn't have any
2 knowledge of Cephalon or Teva USA engaging in any of
3 the conduct that's been described here?

4 A. No. That's true and -- specific
5 recollection involved Cephalon's marketing strategy,
6 no.

7 Q. If you turn to the last paragraph,
8 paragraph 49 --

9 A. Um-hum.

10 Q. -- there's a "Conclusion" before that.
11 Do you see that?

12 A. Yes.

13 Q. And there are a number of statements in
14 there. Do you see that?

15 A. Yes.

16 Q. And I'm happy to walk through each of these
17 statements with you. But for the interest of time,
18 why don't I try to cut to the chase.

19 Anything in this paragraph that you have
20 personal knowledge of Cephalon doing --

21 MR. BECKWORTH: Objection. Same
22 objection we've been having.

23 THE WITNESS: No. I have no specific
24 recollection that Cephalon engaged in the conduct
25 that I was summarizing in this conclusory paragraph.

1 BY MR. ERCOLE:

2 Q. Any personal knowledge of Teva USA engaging
3 in that conduct?

4 A. No.

5 MR. BECKWORTH: Same objection.

6 BY MR. ERCOLE:

7 Q. Any personal knowledge of Cephalon or Teva
8 USA engaging in that conduct in Oklahoma?

9 A. No.

10 Q. Are you aware of anything false or
11 misleading attributed to Cephalon that it caused an
12 inappropriate opioid prescription to be written?

13 MR. BECKWORTH: Same objection.

14 MS. SPENCER: You can answer to the
15 extent you know.

16 THE WITNESS: I'm sorry. Could you
17 repeat it.

18 BY MR. ERCOLE:

19 Q. Sure. Are you aware of anything false or
20 misleading -- I'll reframe it.

21 Are you aware of anything false or
22 misleading that Cephalon has said that has caused an
23 inappropriate opioid prescription to be written?

24 A. By a specific prescriber?

25 Q. Just generally. Are you aware of anything

1 that Cephalon has -- anything false or misleading
2 that Cephalon has said that has caused an
3 inappropriate opioid proscription to be written?

4 MR. BECKWORTH: Same objection.

5 MS. SPENCER: I think his question is
6 valid. Do you mean by "has caused an inappropriate
7 prescription to be written" by any particular
8 prescriber or . . .

9 MR. ERCOLE: Sure. I'll -- we'll go
10 with that question.

11 BY MR. ERCOLE:

12 Q. Are you aware of anything false or
13 misleading said by Cephalon that has caused any
14 particular prescriber to write anything -- any
15 opioid prescription that was inappropriate?

16 A. No, I'm not aware.

17 MR. BECKWORTH: Same objection. I've
18 just noted that your four hours are up. I had left
19 about two minutes of time, which I would request to
20 use.

21 MS. SPENCER: Where are we just --

22 THE VIDEO OPERATOR: Eight hours,
23 one minute.

24 MR. ERCOLE: I mean, I think I can
25 finish, if it's okay with you, counsel, within the

1 next 15 minutes.

2 MS. SPENCER: Okay.

3 MR. BECKWORTH: Well, that's -- you
4 know, I was respectful of the four-hour time period
5 and kept it short, and now you're going over, which
6 means I'm going to have to go over, or at least
7 request to do that.

8 MR. ERCOLE: Well, in all fairness,
9 Judge Hetherington's order was pretty clear about
10 the State getting four hours and the defendants
11 getting six hours.

12 MR. BECKWORTH: No. It was clear
13 that --

14 MR. ERCOLE: Let me just -- let me just
15 finish.

16 MR. BECKWORTH: It's not clear and
17 you're -- you know, it would be one thing if you
18 were actually telling the truth in your questions of
19 this witness, which you're not.

20 I mean, there's 40 million pages of
21 documents, which you know, and all the things you're
22 asking about are just document after document after
23 document after document. You know that.

24 MR. ERCOLE: Sir, you may not like his
25 testimony --

1 MR. BECKWORTH: No. I like his
2 testimony.

3 MR. ERCOLE: -- but I'm going to ask the
4 questions --

5 MR. BECKWORTH: It's great.

6 MR. ERCOLE: -- and let me just put it
7 on --

8 MR. BECKWORTH: You even qualified him
9 as the world's leading expert on pain, which is also
10 great. So we're fine with that. But I'm just
11 telling you I'm --

12 MR. ERCOLE: Are you done? Let me know
13 when you're done.

14 MR. BECKWORTH: With my questions? I'm
15 going to have questions if Amy will let me ask them.

16 MR. ERCOLE: Are you done speaking?

17 MR. BECKWORTH: At this point?

18 MR. ERCOLE: Yes.

19 MR. BECKWORTH: Sure.

20 MR. ERCOLE: I'm going to say something.
21 Is it all right if I finish my statement without you
22 interrupting me?

23 MR. BECKWORTH: I mean, if you say
24 something objectionable, I'll object, but it depends
25 on what you're going to say.

1 MR. ERCOLE: So just to get on the
2 record as you're --

3 MS. SPENCER: Yes, go ahead.

4 MR. ERCOLE: -- Dr. Portenoy, as your
5 counsel knows, Judge Hetherington indicated that the
6 State would have four hours, the defendants would
7 have six hours. Now, I appreciate it was a
8 recommendation, and I appreciate we've --

9 MS. SPENCER: That's not --

10 MR. ERCOLE: -- made that --

11 MS. SPENCER: I'll object. That's not
12 what the order provided.

13 MR. ERCOLE: Well, we --

14 MR. BECKWORTH: Told you.

15 MR. ERCOLE: -- we may disagree on that.
16 But fair enough. The request is obviously that I'd
17 like maybe 15 more minutes or so and we'll -- I'll
18 wrap up then.

19 MS. SPENCER: I will absolutely grant
20 you 15 more minutes. My understanding of the order,
21 and what my agreement is, is that you will have
22 equal time. So along those lines, I will also
23 permit Attorney Beckworth to ask 15 more minutes --
24 15 minutes' worth of questioning as well. And
25 that's equal time.

1 MR. ERCOLE: Sorry, sir. Before I was
2 interrupted by the back-and-forth here, I need to go
3 back and check where I was. I apologize for that
4 interruption.

5 MR. BECKWORTH: And while you're doing
6 that, just to be fair, to respect Amy's wishes, if
7 you don't go that long, that's fine. If you stop
8 now, I'll take the three or whatever we're over, to
9 be fair to everyone --

10 MR. ERCOLE: Thank you.

11 MR. BECKWORTH: -- meaning equal time.

12 BY MR. ERCOLE:

13 Q. So let me -- so my question is, are you
14 aware of any false or misleading statement said by
15 Teva USA that has caused any particular prescriber
16 to write an opioid prescription that was
17 inappropriate?

18 MR. BECKWORTH: Same --

19 THE WITNESS: No, not to my knowledge.

20 BY MR. ERCOLE:

21 Q. And certainly not in Oklahoma; is that fair
22 to say?

23 MR. BECKWORTH: Same objection.

24 THE WITNESS: Correct.

25

1 BY MR. ERCOLE:

2 Q. Are you -- Dr. Portenoy, are you aware that
3 Cephalon manufactures a drug by the name of Actiq?

4 A. Yes.

5 Q. And are you aware that Cephalon
6 manufactures a drug by the name of Fentora?

7 A. Yes.

8 Q. Have you ever prescribed Actiq or Fentora?

9 A. Yes.

10 Q. Have you ever prescribed Actiq or Fentora
11 for breakthrough pain in patients who do not have
12 cancer?

13 A. Yes.

14 Q. Can you describe some of those
15 circumstances where you've done that.

16 MS. SPENCER: Again, within the confines
17 of HIPAA, yes.

18 BY MR. ERCOLE:

19 Q. And I apologize. Yes. I don't need you to
20 disclose names or specific information. Just --

21 A. Yes.

22 Q. -- some examples where that has happened.

23 A. Well, I recall one patient who has a
24 diagnosis of a condition called medullary sponge
25 kidney. This patient makes kidney stones and has

1 had multiple episodes of kidney stones literally
2 every month. And she has chronic abdominal and
3 flank pain with frequent flares of pain associated
4 probably with the passage of gravel and stones
5 through her renal system.

6 And that patient is being treated with a
7 long-acting opioid and access to Actiq for the
8 treatment of breakthrough pain. And she's been
9 receiving that under my care for probably about
10 15 years.

11 Q. Has she benefitted from the prescriptions
12 of Actiq?

13 A. Yes, definitely.

14 Q. And how has she benefitted?

15 A. She describes having a normal life as a
16 result of continuing access to her opioid. She's
17 raised a family. She motorcycles.

18 Q. Are there other instances where you've
19 prescribed Actiq or Fentora for breakthrough pain in
20 patients who are not -- who don't have cancer?

21 A. Yeah. I'm fairly certain that there are,
22 but I can't remember any individual cases now to
23 share with you. She's the only patient that I
24 continue to treat in that way.

25 Q. Is it fair to say that if that patient was

1 not prescribed Actiq, that that patient might have
2 to go to the emergency room to handle the
3 breakthrough pain?

4 A. Yes, that's -- I think that would be clear.

5 Q. And is it fair to say that for her, the
6 Actiq prescriptions that she received enable her to
7 have a more productive life?

8 A. Yes.

9 Q. Dr. Portenoy, you have not been -- you've
10 not been designated by the State to provide any
11 expert testimony in this case, correct?

12 A. Correct.

13 Q. And you're not sitting here today providing
14 any expert testimony, are you?

15 A. No.

16 MR. BECKWORTH: Objection. To the
17 extent he's qualified to testify based on his
18 knowledge, personal experience and qualifications,
19 he can offer testimony any which way the judge
20 allows.

21 And you qualified him as the -- and I
22 quote -- one of the world's leading experts on pain.

23 MR. ERCOLE: Well, we'll disagree on
24 that.

25

1 BY MR. ERCOLE:

2 Q. But thank you for your answer, I appreciate
3 that, sir.

4 Are you aware of something called -- and
5 I promise you I'm wrapping up -- are you aware of
6 something called the Transmucosal Immediate Release
7 Fentanyl Risk Evaluation and Mitigation Strategy?

8 A. Yes.

9 Q. Is that euphemistically known as the "TIRF
10 REMS"?

11 A. Yes.

12 Q. Was that passed in 2011?

13 A. I don't know the exact date, but that
14 sounds right.

15 Q. And what is the TIRF REMS program?

16 A. It's a program that mandates that the
17 describing of the so-called TIRF products, such as
18 Actiq and Fentora, has to be accompanied by
19 completion of an online educational program by the
20 physician and also has to be accompanied by
21 documentation that the patient has received
22 educational materials.

23 Q. And so I'm going to -- I don't want to
24 keep -- I don't want to show you lots of additional
25 documents. So let me ask some questions about this

1 and hopefully you have knowledge of these areas.

2 Have you been enrolled in the TIRF REMS
3 program?

4 A. Yes.

5 Q. Are you still enrolled in the TIRF REMS
6 program?

7 A. Yes.

8 Q. You mentioned that -- is it fair to say
9 that before a doctor is able to prescribe an Actiq
10 or Fentora prescription, he or she has to complete
11 an online educational program?

12 A. Yes.

13 Q. And does that online educational program
14 describe the risks of misuse, abuse, addiction
15 associated with Actiq?

16 A. Yes.

17 Q. Does the online program discuss the
18 indications of Actiq and Fentora?

19 A. Yes.

20 Q. Does the online program, is it geared
21 towards having Actiq or Fentora prescribed to
22 patients who it would be appropriate for?

23 A. Yes.

24 Q. Is it fair to say that a provider before he
25 or she can prescribe Actiq or Fentora has to be

1 certified through that process; is that correct?

2 A. Yes, that's correct.

3 Q. And does the provider also have to certify
4 that he or she will review a medication guide for
5 the TIRF medicine with the patient and provide that
6 medication guide to the patient?

7 A. You know, I don't recall if it has to be
8 provided by the provider, by the prescriber, or by
9 the pharmacist. But the patient has to receive
10 education on the product.

11 Q. And what type of education would the
12 patient receive in connection with that?

13 A. Education about safe dosing, about safe
14 disposal, about keeping the drug away from other
15 people.

16 Q. Education about the potential for abuse of
17 those medicines?

18 A. I don't recall. It's been a while since I
19 read the patient education materials, so I don't
20 recall whether that specific information is down on
21 the patient side. It's certainly there on the
22 physician side.

23 Q. When you say "on the physician side," what
24 are you referring to?

25 A. In the online education program that one

1 has to complete, which incorporates a quiz that you
2 have to score high enough in order to get to
3 certify.

4 MR. ERCOLE: And so let me just mark
5 this as Exhibit 41.

6 (Portenoy Exhibit 41 was marked
7 for identification.)

8 BY MR. ERCOLE:

9 Q. Dr. Portenoy, you're not a marketing
10 expert, correct?

11 A. Correct.

12 Q. Sir, this is a document -- this is the TIRF
13 REMS program document. It comes from the FDA
14 website. If you turn to the second page, do you see
15 that?

16 A. Um-hum, yes.

17 Q. It talks about "REMS elements"?

18 A. Um-hum, yes.

19 Q. And then there's a "B. Elements to assure
20 safe use."

21 Do you see that?

22 A. Yes.

23 Q. And it talks about the need for health care
24 providers, before writing a TIRF medicine, to be
25 certified?

1 A. Yes.

2 Q. And if you turn to, it looks like

3 B(1)(b)(ii), do you see that?

4 A. Yes.

5 Q. It says, "Complete and sign the prescriber
6 enrollment form"?

7 A. Yes.

8 Q. And it lists a number of requirements that
9 prescribers have to acknowledge before an Actiq or
10 Fentora prescription is written; do you see that?

11 A. Yes.

12 Q. And it says, if you look at (b),
13 "I understand that TIRF medicines can be abused and
14 that this risk should be considered when prescribing
15 or dispensing TIRF medicines in situations where I
16 am concerned about an increased risk of misuse,
17 abuse, or overdose, whether accidental or
18 intentional."

19 Do you see that?

20 A. Yes.

21 Q. So is it fair to say that at least since
22 the passage of the TIRF REMS program, before a
23 physician can write a prescription for Actiq or
24 Fentora, he or she has to acknowledge that there are
25 significant risks associated with misuse, abuse, or

1 overdose with that medicine?

2 A. Yes. Since the TIRF program has been in
3 place, that's true.

4 Q. And are you aware that before the TIRF REMS
5 program was in place, that there were specific risk
6 maps associated with Actiq and Fentora?

7 A. I have a recollection of that but I don't
8 remember any of the specifics.

9 Q. But sitting here today, you do recall that
10 there were RiskMAP programs associated with Actiq
11 and Fentora before the passage of TIRF REMS,
12 correct?

13 A. Yes. I remember that there were such
14 programs.

15 Q. And if you go down to B(1)(b)(i), it's on
16 page 3.

17 A. Yes.

18 Q. And it talks about "I will complete and
19 sign a TIRF REMS access patient-prescriber agreement
20 form with each new patient, before writing the
21 patient's first prescription for a TIRF medicine,
22 and renew the agreement every two years."

23 Do you see that?

24 A. Yes.

25 Q. To the best of your recollection, what is

1 your understanding of the patient-prescriber
2 agreement mandated by the TIRF REMS program?

3 A. It's a document that's signed by the
4 patient and the prescriber so that the patient and
5 the prescriber have both read the information about
6 the safe use of the drug.

7 Q. And if you turn to the next page, page 4,
8 we don't need to discuss all of these requirements,
9 but if you look at page 4, it talks about "In
10 signing the patient-prescriber agreement form, the
11 prescriber documents the following:"

12 Do you see that?

13 A. Yes.

14 Q. And if you look to (7), it says, "I have
15 counseled my patient or their caregiver about the
16 risks, benefits, and appropriate use of TIRF
17 medicines, including communication of the following
18 safety messages:"

19 Do you see that?

20 A. Yes.

21 Q. And then it lists a number of safety
22 messages?

23 A. Um-hum, yes.

24 Q. And at least with respect to your
25 prescribing of Actiq and Fentora, have you always

1 complied with the TIRF REMS program?

2 A. Yes.

3 Q. Is it your understanding that Actiq or
4 Fentora can't be dispensed to a prescriber who has
5 not enrolled in the TIRF REMS program?

6 A. Yeah. Can't be dispensed from a
7 prescription written by a prescriber who hasn't
8 enrolled in the program.

9 Q. Thank you, sir. I apologize. It's late
10 and I'm sure that was a very inarticulate question.

11 And then if you turn to the next page --

12 A. Yes.

13 Q. -- it discusses the -- continues to discuss
14 the patient-prescriber agreement; do you see that?

15 A. Yes.

16 Q. And it talks about "I will ensure that the
17 patient and/or caregiver understand that . . . "

18 Do you see that?

19 A. Yes.

20 Q. And then they document the following and
21 there are a number of pieces there?

22 A. Yes.

23 Q. Do you see that?

24 A. Um-hum.

25 Q. And it says, "My prescriber has given me a

1 copy of the medication guide for the TIRF medicine I
2 have been prescribed, and has reviewed it with me."

3 Do you see that?

4 A. Yes.

5 Q. And that is something that the patient
6 would have to acknowledge, correct, in connection
7 with the patient-prescriber agreement form?

8 A. Yes.

9 Q. And the medication guide would contain the
10 product insert for Actiq, correct?

11 A. Yes.

12 Q. And it would contain the product insert for
13 Fentora if that's being prescribed?

14 A. Yes.

15 Q. And then if you'd turn just to page 7 of
16 the document.

17 A. Um-hum.

18 Q. It talks about "TIRF medicines will only be
19 dispensed by pharmacies that are specially
20 certified."

21 Do you see that?

22 A. Yes.

23 Q. Do you understand the requirements that
24 pharmacies have to go through in order to be
25 certified to write a prescription of Actiq or

1 Fentora?

2 A. No.

3 Q. Is your understanding based upon this
4 document that there are specific requirements?

5 A. Yes.

6 MS. SPENCER: We're getting there?

7 MR. ERCOLE: Yeah. Give me 10 seconds
8 just to check my notes and then I will wrap up, I
9 promise.

10 BY MR. ERCOLE:

11 Q. Sitting here today, sir, are you aware of
12 any prescriber in Oklahoma who was not aware of the
13 risks and indications of Actiq or Fentora before
14 they wrote -- before he or she wrote an Actiq or
15 Fentora prescription?

16 A. No, I'm not.

17 Q. And given the TIRF REMS program, would you
18 agree that at least since the TIRF REMS program, all
19 doctors, before they write those prescriptions,
20 would have to be aware of the risks of those
21 medicines?

22 A. Yes.

23 Q. And they'd have to be aware of the
24 indications of those medicines?

25 A. Yes.

1 MR. ERCOLE: Thank you.

2 MS. SPENCER: All right. What do we
3 have for time?

4 THE VIDEO OPERATOR: We're at
5 eight hours, 19 minutes.

6 (Discussion off the record.)

7 MR. BECKWORTH: Everybody ready? We'll
8 make this quick and we'll go home.

9 EXAMINATION

10 BY MR. BECKWORTH:

11 Q. Dr. Portenoy, it's been a long day, hasn't
12 it?

13 A. It has.

14 Q. Just to refresh your memory, my name's Brad
15 Beckworth, and I have the great privilege of
16 representing the State of Oklahoma in this lawsuit.

17 Do you remember that?

18 A. I do.

19 Q. Now, I just want to ask you a few questions
20 about what this drug company lawyer just got done
21 asking you. Now, do you remember when the drug
22 company lawyer started asking you questions, your
23 attorney tried to get him to identify who he worked
24 for?

25 A. Yes.

1 Q. And he said, Well, we'll get to that; do
2 you remember that?

3 A. Yes.

4 Q. And you were asked a series of questions by
5 that drug company lawyer about what Actavis and
6 other companies made; do you remember that?

7 A. Yes.

8 MR. ERCOLE: Objection to form.

9 BY MR. BECKWORTH:

10 Q. And you said, Well, sometimes these drug
11 companies buy other companies and other drugs and
12 they change, and it's hard to keep track with, right?

13 A. Yes.

14 MR. ERCOLE: Objection to form.

15 BY MR. BECKWORTH:

16 Q. You gave him a chance to tell you about
17 what drugs his companies made, didn't you?

18 MR. ERCOLE: Objection to form.

19 THE WITNESS: I did, yes.

20 BY MR. BECKWORTH:

21 Q. Did he ever stop and slow down with his
22 questions and tell you, You know, you're right.
23 There's some changes that have been had?

24 A. No.

25 Q. He didn't do that, did he?

1 A. No.

2 Q. All right. And I don't have the ability to
3 get a printer right here, so I'm just going to hand
4 you something on my phone. This is a Business Wire
5 ad, if I may pass this to you. Right there, would
6 you read for the jury what's in the headline on that
7 Business Wire ad.

8 MR. ERCOLE: Objection to form,
9 foundation.

10 MR. BECKWORTH: The foundation is that
11 your company bought a drug company.

12 MR. ERCOLE: You're not going to print
13 it out and show him the document? Fine. Fair
14 enough. Go ahead and read what's on Mr. Beckworth's
15 phone.

16 MS. SPENCER: I can --

17 MR. EHSAN: From his phone? He objected
18 to my use of something that didn't have a precise
19 date. Now you're using his phone as a --

20 MS. SPENCER: I was going to say, I can
21 print this out. Let me print the document -- I'll
22 print the document if you want to use it. My
23 assistant printed some documents for you guys
24 earlier today, and I'm happy to print documents for
25 him and for you.

1 MR. BECKWORTH: Let's take a break,
2 everybody can sit tight so we don't lose any time,
3 and I'll send two to Amy right now. Thank you.

4 THE VIDEO OPERATOR: Off the record,
5 10:07.

6 (Recess at 10:08 p.m.,
7 resumed at 10:14 p.m.)

8 THE VIDEO OPERATOR: Back on, 10:14.

9 (Portenoy Exhibit 42 was marked
10 for identification.)

11 BY MR. BECKWORTH:

12 Q. Dr. Portenoy, we had a little kerfuffle
13 because I showed you my phone, and the lawyers on
14 the other side of the table, they didn't like that
15 very much, now did they?

16 A. Yeah.

17 MR. ERCOLE: Objection to form.

18 BY MR. BECKWORTH:

19 Q. So we went and printed out what was on my
20 phone. Now, we have added -- what number exhibit is
21 that, sir?

22 A. 42.

23 Q. Now, when that lawyer over there was asking
24 you about all these different names of companies and
25 you said, Well, it gets a little -- you know,

1 sometimes -- I'm paraphrasing -- but it gets a
2 little confusing because they buy and acquire, right?

3 A. Yes.

4 MR. ERCOLE: Objection to form.

5 BY MR. BECKWORTH:

6 Q. He never stopped and told you what's on
7 this document, did he?

8 A. No.

9 Q. Now, what's on the headline of that
10 document?

11 A. "Actavis acquires Kadian; extends specialty
12 drug portfolio in U.S."

13 Q. And then in the first line of this
14 December 30, 2008 document it says, "Actavis today
15 announced it has acquired the brand name drug Kadian
16 from" who?

17 A. "King Pharmaceuticals."

18 Q. Now, when you look in your declaration, we
19 don't have to go through it, but King Pharmaceuticals
20 is one of the companies that provided funding that
21 we talked about today, right?

22 A. Yes.

23 MR. ERCOLE: Objection to form.

24 BY MR. BECKWORTH:

25 Q. Now, I also have handed you Exhibit 7 that

1 we looked at earlier today, sir. And I've turned to
2 that document to something that says "Guilty plea
3 agreement."

4 Do you see that?

5 A. Yes.

6 Q. And you were asked by the Cephalon's drug
7 company lawyer about whether you recalled Cephalon
8 making false statements that affected prescribing
9 habits in the United States of America.

10 Do you remember that?

11 A. Yes.

12 Q. And they even said in Oklahoma; do you
13 remember that?

14 A. Yes.

15 Q. And what he was trying to say was that
16 there were no such statements, but your testimony
17 was simply that you didn't recall them, right?

18 MR. ERCOLE: Objection to form.

19 THE WITNESS: That is correct.

20 BY MR. BECKWORTH:

21 Q. You weren't testifying, were you, that you
22 weren't aware of any statements?

23 MR. ERCOLE: Objection to form. His
24 testimony speaks for itself.

25 THE WITNESS: I said I had no specific

1 recollection.

2 BY MR. BECKWORTH:

3 Q. You didn't recall?

4 A. That's right.

5 Q. Now, I'll represent to you, sir, there's
6 something like 30, 40 million pages of documents
7 produced by the defendants in this case. Now, your
8 attorney has given me four hours and now about
9 15 extra minutes to talk to you today, right?

10 A. Right.

11 Q. There's no way I could have given you every
12 document I have in this case, right?

13 A. Right.

14 Q. But you're not suggesting that Cephalon
15 didn't actually make misrepresentations? It's just
16 that you don't recall them, right?

17 MR. ERCOLE: Objection to form.

18 THE WITNESS: That's right.

19 BY MR. BECKWORTH:

20 Q. Now, did that lawyer over there on the
21 other side of the table, did he show you any
22 documents from Cephalon about them making
23 misstatements?

24 A. No.

25 Q. And while he sat in this very room where

1 you were under oath under penalty of perjury, he had
2 you say that you didn't recall any statements that
3 Cephalon made about any opioid, right?

4 MR. ERCOLE: Objection to form,
5 mischaracterizes testimony.

6 THE WITNESS: Right.

7 BY MR. BECKWORTH:

8 Q. Now, he was in the room when I was asking
9 you questions this morning now, wasn't he?

10 A. Yes.

11 Q. And he would have had to have been asleep
12 to not see that we went over Exhibit 7, right?

13 MR. ERCOLE: Objection to form.

14 THE WITNESS: I can't state that he'd
15 have to be asleep, but he didn't comment on it,
16 right.

17 BY MR. BECKWORTH:

18 Q. Well, you were here. Was he sleeping?

19 A. Not that I was aware of.

20 Q. And we went over Exhibit 7, didn't we?

21 A. We did.

22 Q. Now, let's turn to this page, "Guilty plea
23 agreement." It's page 29 of 41. Right there on the
24 top it says, "United States of America vs. Cephalon,"
25 right?

1 A. Yes.

2 Q. Now, that lawyer over there when your
3 lawyer asked him who he represented, he said, We'll
4 get to that, right?

5 A. Yes.

6 Q. Did he ever come out and say, I represent
7 Cephalon?

8 MR. ERCOLE: Objection to form.

9 MS. SPENCER: You can answer if you
10 know.

11 THE WITNESS: Not that I recall.

12 MR. ERCOLE: Sorry, sir.

13 Do you mind -- Amy, is there a way that
14 I can use your exhibit for these questions? I just
15 want to follow --

16 MR. COLEMAN: They just got shuffled
17 around.

18 MR. ERCOLE: Sorry for interrupting your
19 question.

20 MS. SPENCER: No problem.

21 BY MR. BECKWORTH:

22 Q. If you'll turn to page 32 of 41, which is
23 page 4 of that "Guilty plea agreement."

24 A. Yes.

25 Q. Paragraph 6, Part A says -- it says right

1 there, "The parties stipulate to the following facts
2 and basis for the plea, criminal fine and
3 forfeiture."

4 Do you see that?

5 A. Yes.

6 Q. No. (1) it says Cephalon marketed three
7 different drugs, one of which is Actiq. Do you
8 remember that?

9 A. Yes.

10 Q. And you see it right there in front of your
11 face, correct?

12 A. Yes.

13 MR. ERCOLE: Objection to form.

14 BY MR. BECKWORTH:

15 Q. Now, if you'll turn to page 5 where we get
16 to Actiq, which is how I pronounce it, we've got
17 paragraphs (8) and (9).

18 Do you see that?

19 A. Yes.

20 Q. Now, please read for the jury what
21 paragraph (8) says.

22 A. Paragraph (8) says, "Between January 2001
23 and October 1, 2001, Cephalon promoted Actiq for
24 uses not approved by the FDA, including for
25 noncancer pain uses, such as injuries and migraines.

1 Cephalon's promotion of Actiq for these additional
2 intended uses violated" some designated regulation
3 or law "because Actiq's labeling did not bear
4 adequate directions for each of the drug's intended
5 uses."

6 Q. Now, that's about using an opioid labeled
7 for cancer treatment for noncancer use, correct?

8 MR. ERCOLE: Objection to form.

9 BY MR. BECKWORTH:

10 Q. That's what --

11 MR. ERCOLE: The document speaks for
12 itself.

13 THE WITNESS: Yes, that's true.

14 BY MR. BECKWORTH:

15 Q. It does speak for itself and that's exactly
16 what it says, isn't it?

17 A. Yes.

18 Q. And in paragraph (9), it says, "Between
19 2001 through October 1, 2001, Cephalon profited by
20 misbranding Provigil, Gabitril, and Actiq, and
21 distributing these drugs in interstate commerce."

22 It says that, right?

23 A. Yes.

24 Q. Now, if you'll do me a kind favor of
25 turning to what at the top says page 38 of 41 of

1 that document.

2 A. Yes.

3 Q. That document is signed on behalf of
4 Cephalon by an attorney.

5 Do you remember that?

6 A. Yes.

7 Q. Do you remember a minute ago when Purdue
8 was asking you questions, they pulled out a document
9 in the New York case that your attorney had filed,
10 right?

11 A. Yes.

12 Q. And they tried to ask you questions about
13 stuff that your attorney put in a pleading; do you
14 remember that?

15 A. Yes. Yes.

16 Q. Here we've got a lawyer signing a criminal
17 plea agreement for Cephalon as their attorney, don't
18 we?

19 A. Yes.

20 Q. And at the top of this document, we see
21 "Gerald J. Pappert, executive vice president and
22 general counsel" for "Cephalon, Inc."

23 Do you see that?

24 A. Yes.

25 Q. It's dated September, looks likes, 15, 2008?

1 A. Yes.

2 Q. And underneath that, Cephalon's attorney
3 signed it, right?

4 A. Yes.

5 Q. And can you read the name of that attorney?

6 A. I believe it's "Eric W. Sitarchuk."

7 Q. And under that, Mr. Sitarchuk has a law
8 firm that he works for, right?

9 A. Yes.

10 MR. ERCOLE: Objection to form.

11 BY MR. BECKWORTH:

12 Q. And what is the name of that law firm?

13 A. "Morgan, Lewis & Bockius."

14 Q. "Morgan Lewis . . . LLP, counsel for
15 defendant"?

16 A. Yes.

17 MR. BECKWORTH: I'm going to hand you
18 another exhibit if we can mark this, please.

19 (Portenoy Exhibit 43 was marked
20 for identification.)

21 BY MR. BECKWORTH:

22 Q. Now, that lawyer over there that was asking
23 you the questions and said surely you don't know of
24 any things that were said in the State of Oklahoma
25 or elsewhere that Cephalon did wrong, can you see

1 him? He's to your right. There's a nice lady and
2 another man and then another man?

3 A. Yes.

4 Q. Can you look at his face right now?

5 A. Yes.

6 Q. Now, please look at the exhibit I just
7 handed you. That's Exhibit 43, right?

8 A. Yes.

9 Q. Does that face look familiar to you?

10 A. Yes.

11 Q. Whose name is on that document, Exhibit 43?

12 A. "Brian Ercole."

13 Q. And can you tell us what law firm it says
14 he works for?

15 MR. ERCOLE: Objection to form.

16 BY MR. BECKWORTH:

17 Q. Right there at the top of Exhibit 43.

18 A. "Morgan Lewis."

19 Q. "Morgan Lewis." Now, he didn't tell you
20 that he worked at Morgan Lewis, did he?

21 A. No.

22 MR. ERCOLE: Objection to form.

23 BY MR. BECKWORTH:

24 Q. He didn't tell you -- he did not tell you
25 to look at this page of Exhibit 7 where his law firm

1 signed Cephalon's guilty plea, now did he?

2 A. No.

3 Q. And I bet he also didn't tell you that he
4 has a law partner by the name of Harvey Bartle that
5 works at that same firm?

6 MR. ERCOLE: Objection --

7 BY MR. BECKWORTH:

8 Q. He didn't tell you that either, did he?

9 MR. ERCOLE: Objection to form.

10 THE WITNESS: No.

11 BY MR. BECKWORTH:

12 Q. And he didn't tell you that Harvey Bartle's
13 father is a federal judge who actually presided over
14 Cephalon's criminal plea agreement in the matter
15 before you in Exhibit 7? Never told you that either,
16 did he?

17 A. No.

18 MR. ERCOLE: Objection to form.

19 BY MR. BECKWORTH:

20 Q. Now, he had every opportunity. He not only
21 went four hours, but your attorney gave him extra
22 time to complete his questioning, right?

23 A. Yes.

24 MR. ERCOLE: Objection to form. That's
25 not true but --

1 BY MR. BECKWORTH:

2 Q. Neither I nor anyone else in this room
3 tried to stop him from telling you about what was in
4 this exhibit, right?

5 A. Right.

6 MR. ERCOLE: Objection to form.

7 BY MR. BECKWORTH:

8 Q. So let's look at this exhibit a little
9 more. If you'll turn, please, sir, to page 3 of 41
10 of Exhibit 7, I'm just going to read it for you to
11 save a little time. It says there in the bottom
12 half, "The information describes the defendant's
13 off-label practices and its training of its sales
14 staff to ignore the legal restrictions on promoting
15 these drugs."

16 Do you see that?

17 A. Yes.

18 Q. And it says, "In particular: Cephalon had
19 its sales representatives call on doctors who would
20 not normally prescribe the defendant's drugs in the
21 course of the doctor's practice."

22 It says it right there, doesn't it?

23 A. Yes.

24 Q. It says, "Cephalon trained its sales
25 representatives on techniques to prompt the doctors

1 into off-label conversation," right?

2 A. Yes.

3 Q. And it says that "Cephalon's compensation
4 and bonus structure encouraged off-label marketing,"
5 right?

6 A. Yes.

7 Q. And it says that "Cephalon had its sales
8 representatives tell doctors how to document their
9 off-label use of drugs to get these uses paid by
10 insurers, who often will not pay for off-label uses"?

11 A. Yes.

12 Q. And it says, "Cephalon used its grants for
13 continuing medical education" --

14 Now that's something we've talked about
15 today, right?

16 A. Yes.

17 Q. -- "for continuing medical education to
18 promote off-label uses." It says it, doesn't it?

19 A. Yes.

20 Q. And -- now we talked about consultant
21 meetings and speakers today, didn't we?

22 A. Yes.

23 Q. Right here it says, "Cephalon sent doctors
24 to 'consultant' meetings at lavish resorts to hear
25 the company's off-label message."

1 It says that right there, doesn't it?

2 A. Yes.

3 MR. ERCOLE: Objection to form.

4 BY MR. BECKWORTH:

5 Q. Now, if you'll turn to page 10 -- it's
6 actually 10 of 41 -- this is all coming, sir, from
7 the government's memorandum for entry of plea and
8 sentencing. If you will look at page 10 of 41 where
9 it says "A. Actiq."

10 Do you see that?

11 A. Yes.

12 Q. It says right there, "The case of Actiq is
13 particularly egregious, as this drug is 80 to
14 100 times more powerful than morphine."

15 It says that, doesn't it?

16 A. Yes.

17 Q. Morphine's an opioid, isn't it?

18 A. Yes.

19 MR. ERCOLE: Objection to form.

20 BY MR. BECKWORTH:

21 Q. And this is 80 to 100 times more powerful
22 than that, right? Is that right?

23 A. It's 80 to 100 times more potent.

24 Q. Potent.

25 A. It means that a very small quantity can

1 carry the same activity as a much larger quantity of
2 morphine.

3 Q. That's right. Now, you heard Johnson &
4 Johnson's lawyer refer to you as one of the world's
5 leading experts on pain, right?

6 A. Yes.

7 Q. Is being 80 to 100 times more potent than
8 morphine, is that a big deal?

9 A. It increases the risk when you use it,
10 potentially.

11 Q. Increases the risk, right?

12 A. Potentially, yes.

13 Q. So it's not a laughing matter or a little
14 oversight to do false marketing about a drug that's
15 80 to 100 times more potent than morphine?

16 MS. SPENCER: I'll object.

17 MR. ERCOLE: Objection to form.

18 MS. SPENCER: He didn't say -- that's
19 not the witness's words but . . .

20 MR. BECKWORTH: Those are my words.

21 MR. ERCOLE: Right. Objection.

22 MR. BECKWORTH: I'm asking. It's not --

23 MS. SPENCER: If you know, you can
24 answer.

25 THE WITNESS: Yeah.

1 MR. ERCOLE: Objection to form.

2 THE WITNESS: I think that the increased
3 potency is not determinative here. The false
4 advertising, the allegations here, or I guess it's
5 actually a stipulation here, that's a serious
6 business.

7 BY MR. BECKWORTH:

8 Q. And we're talking about an opioid?

9 A. Yes.

10 Q. That Cephalon makes?

11 A. Yes.

12 Q. And when you were asked all these questions
13 about what Cephalon may have done about marketing,
14 continuing education, and speakers and whether you
15 recalled anything, that lawyer did not one time
16 reference anything that we just read out of
17 Exhibit 7, did he?

18 MR. ERCOLE: Objection to form.

19 THE WITNESS: That's correct.

20 BY MR. BECKWORTH:

21 Q. Now, you understand this case has more than
22 20 years of facts behind it, right?

23 A. Right.

24 Q. And when you testified, you talked about
25 facts based on your personal knowledge over the

1 course of your career, correct?

2 A. Yes.

3 Q. And that included papers that went back to
4 the mid 1980s?

5 A. That's correct.

6 Q. It's a lot of information, right?

7 A. Yes.

8 Q. There's no way you could sit here today, is
9 there, and remember everything that you've known in
10 your life?

11 A. Right.

12 MR. ERCOLE: Objection to form.

13 BY MR. BECKWORTH:

14 Q. But when you testified today, did you
15 testify truthfully?

16 A. Yes.

17 Q. And when you signed that declaration, did
18 you state the things in there truthfully?

19 A. Yes.

20 Q. Under penalty of perjury?

21 A. Yes.

22 Q. And you've done that here today, right?

23 A. Yes.

24 Q. Now, when we talk about Cephalon, they
25 never told you that Cephalon and Teva make all kinds

1 of drugs, did they?

2 A. No.

3 MR. ERCOLE: Objection to form.

4 BY MR. BECKWORTH:

5 Q. They make a fentanyl product, Actiq?

6 A. Yes.

7 Q. They make an unbranded version of Actiq --

8 MR. ERCOLE: Objection to form.

9 BY MR. BECKWORTH:

10 Q. -- right?

11 A. Yes.

12 Q. They make a generic version of OxyContin --

13 MR. ERCOLE: Objection to form.

14 BY MR. BECKWORTH:

15 Q. -- right?

16 A. Yes.

17 Q. And he never told you that that generic
18 version of OxyContin is bought from Purdue?

19 He never told you that, did he?

20 A. No.

21 MR. ERCOLE: Objection to form.

22 BY MR. BECKWORTH:

23 Q. And he never told you that when Cephalon or
24 Teva's generic version of OxyContin is sold, they
25 have to pay a royalty to Purdue? Never told you

1 that, did he?

2 MR. ERCOLE: Objection to form.

3 THE WITNESS: No.

4 BY MR. BECKWORTH:

5 Q. And he never told you that Purdue actually
6 compensates Purdue's sales representatives based on
7 the number of generic opioids that are sold by both
8 Cephalon and Endo? He never told you anything about
9 that, did he?

10 A. No.

11 MR. ERCOLE: Objection to form.

12 BY MR. BECKWORTH:

13 Q. Now, he had a full and fair opportunity to
14 do it, right?

15 A. Yes.

16 Q. Now, so when you say as you sit here today
17 that you don't recall specific instances that
18 happened in Oklahoma or anywhere else, you're not
19 saying that those things didn't happen; you're just
20 saying you don't recall them as you sit here today?

21 MR. ERCOLE: Objection to form.

22 THE WITNESS: That's correct.

23 BY MR. BECKWORTH:

24 Q. That's right. And like the gentleman that
25 referred to you as one of the world's leading

1 experts, you understand that in this day and age
2 and, in fact, going back to 1996, much of the
3 marketing and work and speeches and papers that
4 exist in this space, they weren't limited in
5 geography, were they?

6 MR. ERCOLE: Objection to form.

7 THE WITNESS: By "limited in geography,"
8 you mean not distributed throughout the country?

9 BY MR. BECKWORTH:

10 Q. That's correct.

11 A. That's right. They were distributed
12 throughout the country.

13 Q. Throughout the country. In fact, just like
14 today, this is a case about Oklahoma, and we're
15 sitting in New Hampshire, right?

16 A. Yes.

17 Q. And even today, we've looked at papers that
18 you wrote back in 1986, right?

19 A. Yes.

20 Q. Let's just go back to it. You testified at
21 length today, correct?

22 A. Yes.

23 Q. You've been represented by your attorney?

24 A. Yes.

25 Q. And everything that you said under oath

1 when I examined you earlier and just now, you stated
2 truthfully --

3 A. Yes.

4 Q. -- to the best of your knowledge?

5 A. Yes.

6 Q. Based on your experience and qualifications
7 and your life and your work, correct?

8 A. Correct.

9 Q. And your declaration that's admitted into
10 this record was done under penalty of perjury?

11 A. Yes.

12 Q. And it's true and correct?

13 A. Yes.

14 MR. BECKWORTH: Sir, I thank you for
15 your time.

16 MR. ERCOLE: I have --

17 MS. SPENCER: Where are we on time?

18 THE VIDEO OPERATOR: Eight hours,
19 37 minutes.

20 MR. BECKWORTH: We can keep going
21 forever, but that's rebuttal. It's equal time.

22 MR. ERCOLE: -- a couple questions.

23 MR. BECKWORTH: It's equal time.

24 MR. ERCOLE: I don't want to push him to
25 come back. There's probably three questions that I

1 have.

2 MR. BECKWORTH: There's no way that this
3 witness is going to have to come back in this case.
4 That's not true.

5 MR. ERCOLE: Well, if I don't get to ask
6 my questions, then I will probably --

7 MR. BECKWORTH: Sir, trials don't go on
8 forever.

9 MR. ERCOLE: Can I finish?

10 MR. BECKWORTH: No. You do not get --

11 MS. SPENCER: All right.

12 MR. BECKWORTH: You're not the
13 plaintiff. You don't get a rebuttal of a rebuttal.

14 MR. ERCOLE: It's not your decision.

15 MR. BECKWORTH: It's her decision.

16 MS. SPENCER: So where are we?

17 THE VIDEO OPERATOR: Eight hours,
18 38 minutes.

19 MR. ERCOLE: I can do it under five
20 questions.

21 MS. SPENCER: I'm going to say this.
22 If I give you each five more minutes --

23 MR. ERCOLE: I don't need five more
24 minutes.

25 MR. BECKWORTH: Five questions is fine.

1 MS. SPENCER: If I give you each five
2 more minutes, that's what I'm going to do. It's
3 fair, we don't have to come back here, we don't have
4 to argue about this. We can all get out of here.

5 MR. BECKWORTH: Brian said he can do it
6 in five questions, and I bet you I won't have any.

7 EXAMINATION

8 BY MR. ERCOLE:

9 Q. Dr. Portenoy, you have prescribed opioids
10 off-label; is that fair to say?

11 A. Yes.

12 Q. You've prescribed Actiq off-label, correct?

13 A. Yes.

14 Q. You've prescribed Fentora off-label?

15 A. I don't think I've used Fentora, no.

16 Q. Is it fair to say that in some situations,
17 off-label prescribing may form the appropriate
18 standard of care?

19 A. Yes.

20 Q. With respect to the off-label marketing
21 referenced in Plaintiff's Exhibit 7 --

22 A. Yes.

23 Q. -- do you have any knowledge one way or the
24 other -- personal knowledge one way or the other
25 whether Cephalon ever engaged in off-label promotion

1 in Oklahoma?

2 A. I have no personal recollection that I --
3 of that information, no.

4 Q. And you're not aware of anything in this
5 document that says Cephalon engaged in off-label
6 promotion in Oklahoma, correct?

7 A. Correct.

8 MR. ERCOLE: Thank you.

9 MR. PATE: That was six questions.

10 MS. SPENCER: But it was less than five
11 minutes, so we're good.

12 MR. BECKWORTH: We're done. I've got to
13 go to New Jersey.

14 THE VIDEO OPERATOR: The time is 10:33.
15 We're off.

16 (Deposition concluded at 10:33 p.m.)

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24

25

1 C E R T I F I C A T E

2 I, Kimberly A. Smith, a Certified Shorthand
3 Reporter, Certified Realtime Reporter, Certified
4 Realtime Captioner, Registered Diplomate Reporter,
5 and Realtime Systems Administrator in and for the
6 State of New Hampshire, do hereby certify that the
7 foregoing is a true and accurate transcript of my
8 stenographic notes of the deposition of RUSSELL
9 PORTENOY, M.D., who was first duly sworn, taken at
10 the place and on the date hereinbefore set forth.

11 I further certify that I am neither attorney or
12 counsel for, nor related to or employed by any of
13 the parties to the action in which this deposition
14 was taken, and further that I am not a relative or
15 employee of any attorney or counsel employed in this
16 case, nor am I financially interested in this action.

17 THE FOREGOING CERTIFICATION OF THIS TRANSCRIPT
18 DOES NOT APPLY TO ANY REPRODUCTION OF THE SAME BY
19 ANY MEANS UNLESS UNDER THE DIRECT CONTROL AND/OR
20 DIRECTION OF THE CERTIFYING COURT REPORTER.

21 Signed this 27th day of January, 2019.

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KIMBERLY A. SMITH, CSR, CRR, CRC, RDR

1 ERRATA SHEET DISTRIBUTION INFORMATION
2 DEPONENT'S ERRATA & SIGNATURE INSTRUCTIONS
3
4

5 ERRATA SHEET DISTRIBUTION INFORMATION

6 The original of the Errata Sheet has been
7 delivered to S. Amy Spencer, Esquire.

8 When the Errata Sheet has been completed by the
9 deponent and signed, a copy thereof should be
10 delivered to each party of record and the ORIGINAL
11 forwarded to Bradley Beckworth, Esquire, to whom the
12 original deposition transcript was delivered.

13
14
15 INSTRUCTIONS TO DEPONENT

16 After reading this volume of your deposition,
17 please indicate any corrections or changes to your
18 testimony and the reasons therefor on the Errata
19 Sheet supplied to you and sign it. DO NOT make
20 marks or notations on the transcript volume itself.
21 Add additional sheets if necessary. Please refer to
22 the above instructions for Errata Sheet distribution
23 information.

24
25

1 ATTACH TO THE DEPOSITION OF RUSSELL PORTENYOY, M.D.

2 CASE: STATE OF OKLAHOMA vs. PURDUE PHARMA, L.P.

3 DATE TAKEN: January 24, 2019

4 ERRATA SHEET

5 Please refer to page 541 for Errata Sheet

6 instructions and distribution instructions.

7 PAGE LINE CHANGE REASON

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18 _____

19 I have read the foregoing transcript of my
20 deposition and except for any corrections or changes
21 noted above, I hereby subscribe to the transcript as
22 an accurate record of the statements made by me.

23 Executed this _____ day of _____, 2019.

24 _____

25 RUSSELL PORTENYOY, M.D.